

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00968

00961

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Hyattsville		d. STREET ADDRESS 6928 Standish Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion Emma Allen		First Middle Last		4. DATE OF DEATH 1-10-62		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/02		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Mc Guire				14. MOTHER'S MAIDEN NAME Emma Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Stover J. Allen Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia lobar 4-90 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ✓	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patent foramen ovale							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-25, 1961, to 1-10, 1962, that (I) (we) last saw the deceased alive on 1-10, 1962, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE D.R. Purdie M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D.R. Purdie M.D.				22d. ADDRESS 4408 Queensbury Rd. Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		23b. DATE THEREOF Jan 12, 1962		23c. NAME OF CEMETERY OR CREMATORY Alta Vista		23d. LOCATION (City, town or county) (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE JAN 15 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00969
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00962

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt	
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS 34 E Crescent Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CONSTANCE ANN Baby Girl		DATE OF DEATH 16 Jan 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Jan 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME James D ASH BACHER		14. MOTHER'S MAIDEN NAME Ann E NORDWALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT James D. Ashbacher		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Hyaline membrane disease Conditions, if any, which gave rise to immediate cause (b) premature birth (c) DUE TO causing the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/13 1962, to 1/16 1962, that (I) (we) last saw the deceased alive on 1/16 1962, and that death occurred at 12:20AM from the causes and on the date stated above.			
22a. SIGNATURE M. A. Jansa M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Milos A. Jansa		22d. ADDRESS 7403 Varnum St., Landover Hills, Md.	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 1-18-1962	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Blacksburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale, Md		25a. REC'D BY REGISTRAR DATE JAN 19 '62	
		25b. REGISTRAR'S SIGNATURE	

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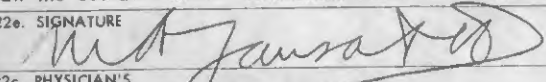
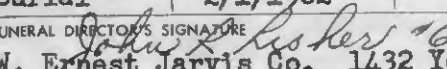

MARYLAND AND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00963

00970

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5205 46th Ave. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lisa J. Ayres		4. DATE OF DEATH Month January Day 27 Year 19 62		5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 12-8-61 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) 1 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unk. 14. MOTHER'S MAIDEN NAME Elizabeth Ayres			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrosis of the left Cerebral hemisphere DUE TO (b) Encephalomalacia (cause undetermined) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-13</u>, 1962 to <u>1-27</u>, 1962, that (I) (we) last saw the deceased alive on <u>1-27</u>, 1962, and that death occurred at <u>1:30</u>, from the causes and on the date stated above.							
22a. SIGNATURE  M.D.				22b. DATE SIGNED P.M.			
22c. PHYSICIAN'S NAME (Type) Dr. Milos A. Jansa				22d. ADDRESS 7403 Varnum Street, Landover Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/1962		23c. NAME OF CEMETERY OR CREMATORY Lincoln			
23d. LOCATION (City, town or county) Suitland, Maryland		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE  W. Ernest Jarvis Co. 1432 You Street, N.W.				25a. REC'D BY REGISTRAR Feb 2 '62 25b. REGISTRAR'S SIGNATURE 			

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VR A15 (4)
 15M 9/60

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Mr. J. Edgar Hoover
Director, Federal Bureau of Investigation
Washington, D. C.

Re: [illegible]
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00971

00964

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN (b) 13 13 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 64 d. STREET ADDRESS 4443 Wells Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Susan Baker		4. DATE OF DEATH January 25 1962		9. AGE (In years last birthday) 13 13 yrs. 1962			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1962		9. AGE (In years last birthday) 13 13 yrs. 1962		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME James F. Baker			14. MOTHER'S MAIDEN NAME Ella F. Baker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mother Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 539.1 Pulmonary Atelectasis (Bilaterally) 539.1 Congenital Stenosis of the Esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/12/62, 1962, to 1-25, 1962, that (I) (we) last saw the deceased alive on 1-25-1962, and that death occurred at 4:45, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Gordon W. Kelley		22b. DATE SIGNED 1/25/62		22c. PHYSICIAN'S NAME (Type) Dr. Gordon W. Kelley			
22d. ADDRESS 6124 - 41st Avenue, Hyattsville, Md.		22e. ADDRESS 6124 - 41st Avenue, Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Removal 1/27/62		23b. DATE THEREOF 1/27/62		23c. NAME OF CEMETERY OR CREMATORY Montavista Park Cem.			
23d. LOCATION (City, town or county) Bluefield, W. Va.		23e. LOCATION (City, town or county) Bluefield, W. Va.					
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md.		24a. ADDRESS 4739 Balt. Ave. Hyattsville, Md.		24b. REC'D BY REGISTRAR JAN 29 '62			
24c. REGISTRAR'S SIGNATURE Arthur S. Kenna		24d. REGISTRAR'S SIGNATURE Arthur S. Kenna					

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Library of the
University of California

VR A15 (4)
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00965

1. PLACE OF BIRTH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN b. 9 HRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS d. STREET ADDRESS 5020 MIDDLETON LANE e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RAYFORD		First H		Middle BELVIN		Last 4. DATE OF DEATH JANUARY 4 1962	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 MARCH 1916	
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TYPE OPERATOR		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME RAYFORD BELVIN				14. MOTHER'S MAIDEN NAME MARY BAKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1948 - 45		17. INFORMANT MRS DELILAH A BELVIN Address SAME AS ITEM #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of the Myocardium 4200 DUE TO (b) Atherosclerosis of Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 14 hours undetermined							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 3 January, 1962 to 4 January, 1962 , that X (we) last saw the deceased alive on 4 January, 1962 , and that death occurred at 450 M from the causes and on the date stated above.							
22a. SIGNATURE Stanley M. Bialek MD M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4 JAN 62	
22c. PHYSICIAN'S NAME (Type) STANLEY M BIALEK CAPT USAF MC				22d. ADDRESS USAF HOSP, ANDREWS AFB, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Jan 7-62		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Durham North Carol	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				ADDRESS 1661 Good Hope Rd SE Wash. 20 DC		25a. REC'D BY REGISTRAR JAN 8 '62	
				25b. REGISTRAR'S SIGNATURE Charles E. Thomas			

(M)

35202

REPORT OF

AGENCY AND FIELD OFFICE

DATE RECEIVED

REPORT OF

DATE RECEIVED

TYPE OF CASE

STATUS OF CASE

1941 - 42

2 JANUARY 1941

DEPT. OF JUSTICE

WASH. D.C.

1941 - 42

It is the policy of the Department to
maintain a close working relationship

Approved by Special Agent in Charge

RECEIVED BY SPECIAL AGENT IN CHARGE

Copy of report of Special Agent in Charge
to Bureau dated 1/11/41

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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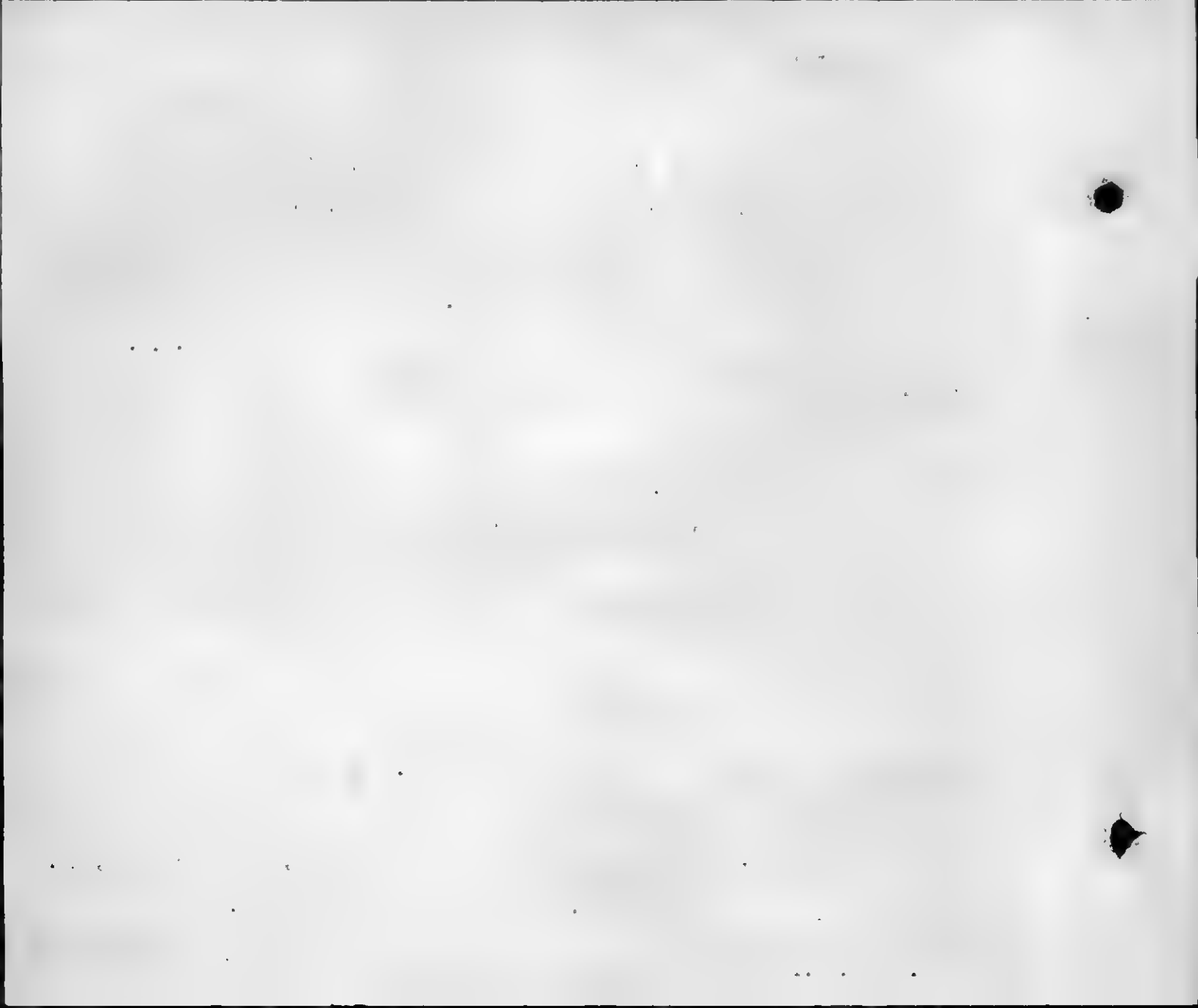
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00973

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00966

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 6901 Sheriff Road	
3. NAME OF DECEASED (Type or print) Baby Girl Blake		4. DATE OF DEATH Month Jan Day 30 Year 19 62	
5. SEX Female 6. COLOR OR RACE Colored Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 29 Jan. 1962	
9. AGE (In years last birthday) 5		10. IF UNDER 1 YEAR Months 5 Days 5	
11. IF UNDER 24 HRS. Hours 5 Min. 5		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbur Chase		14. MOTHER'S MAIDEN NAME Jane E Blake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 166-12-1234	
17. INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth 762.5 DUE TO Pulmonary Atelectasis Conditions, if any, which gave rise to immediate cause (b) 762.5 (c) 762.5 DUE TO Pulmonary Atelectasis (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 62 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 29 Jan 19 62 to 30 Jan 19 62 , that (I) (we) last saw the deceased alive on 30 Jan 19 62 , and that death occurred at 2.00AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Milos A. Jansa		22b. DATE SIGNED 2.00AM	
22c. PHYSICIAN'S NAME (Type) Dr. Milos A. Jansa		22d. ADDRESS 7403 Varnum Street, Landover Hills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-2-62	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		25a. REC'D BY REGISTRAR FEB 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Penn		25c. DATE FEB 6 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

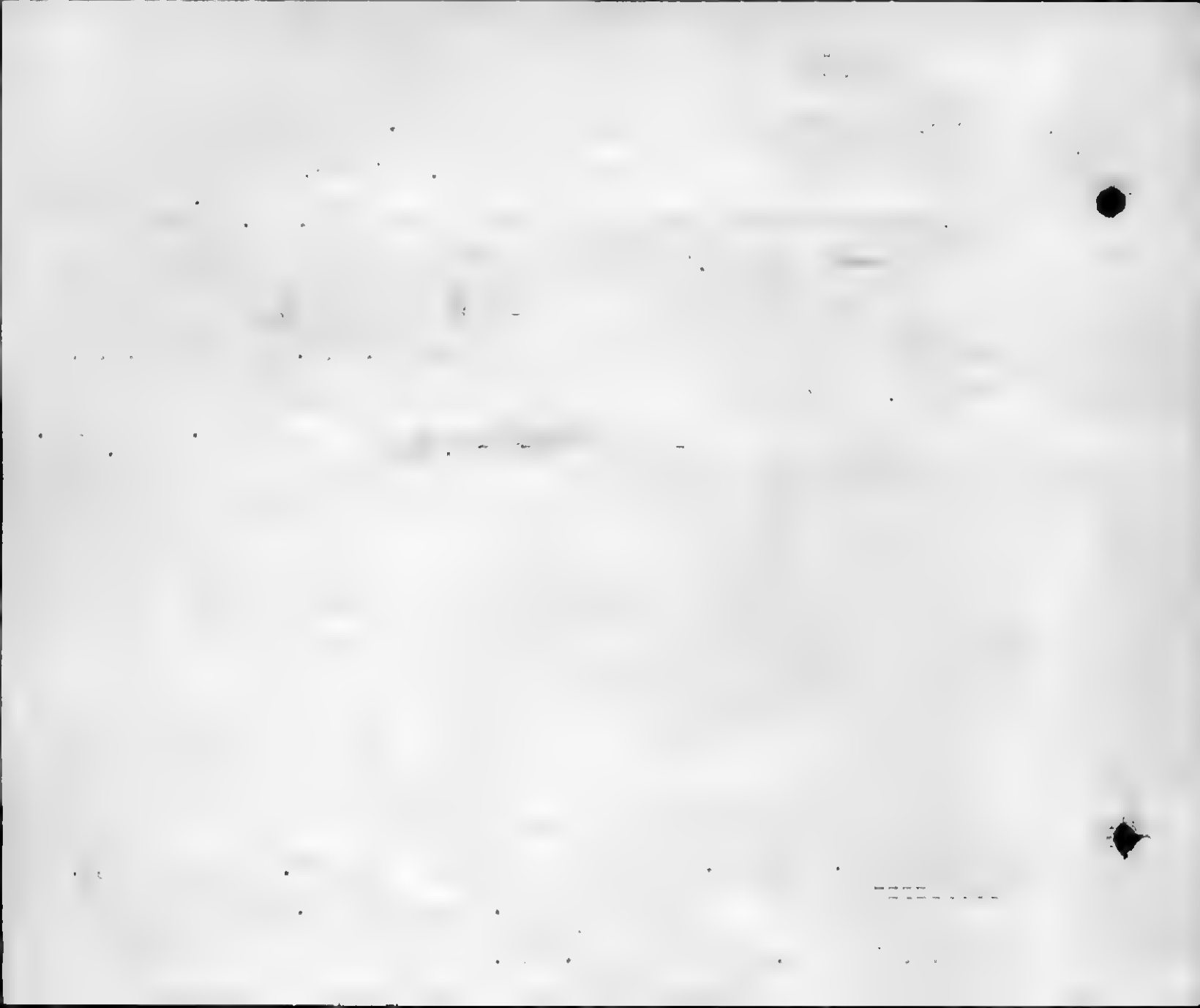
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00974

00967

1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Mt. Rainier,</u> d. STREET ADDRESS <u>4203 Eastern Ave. Mt. Rainier</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Janet Elizabeth Boss</u>		4. DATE OF DEATH <u>January 25 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-17-05</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign) <u>Washington, D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James T. Townsend</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Goodrich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>579-30-3802</u>		17. INFORMATION Address <u>Mt. Rainier, Md.</u> <u>Ernest M. Boss 4203 Eastern Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Portal Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21 I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>62</u> to <u>1-25</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1-20</u> , 19 <u>62</u> and that death occurred at <u>1:20 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William B. Gunther</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Gunther</u>		22d. ADDRESS <u>9812 49th Ave. College Park Md.</u>					
23a. BURIAL, CREMATION, REMOVAL TO OTHER PLACE <u>1/29/62</u>		23b. DATE THEREOF <u>1/29/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>			
23d. LOCATION (City, town or county) <u>Ft. Myer, Virginia</u>		23e. (State) _____					
24 FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		ADDRESS <u>Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 29 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>John S. Hines</u>		DATE <u>JAN 29 '62</u>					

MEDICAL CERTIFICATION



1
00975

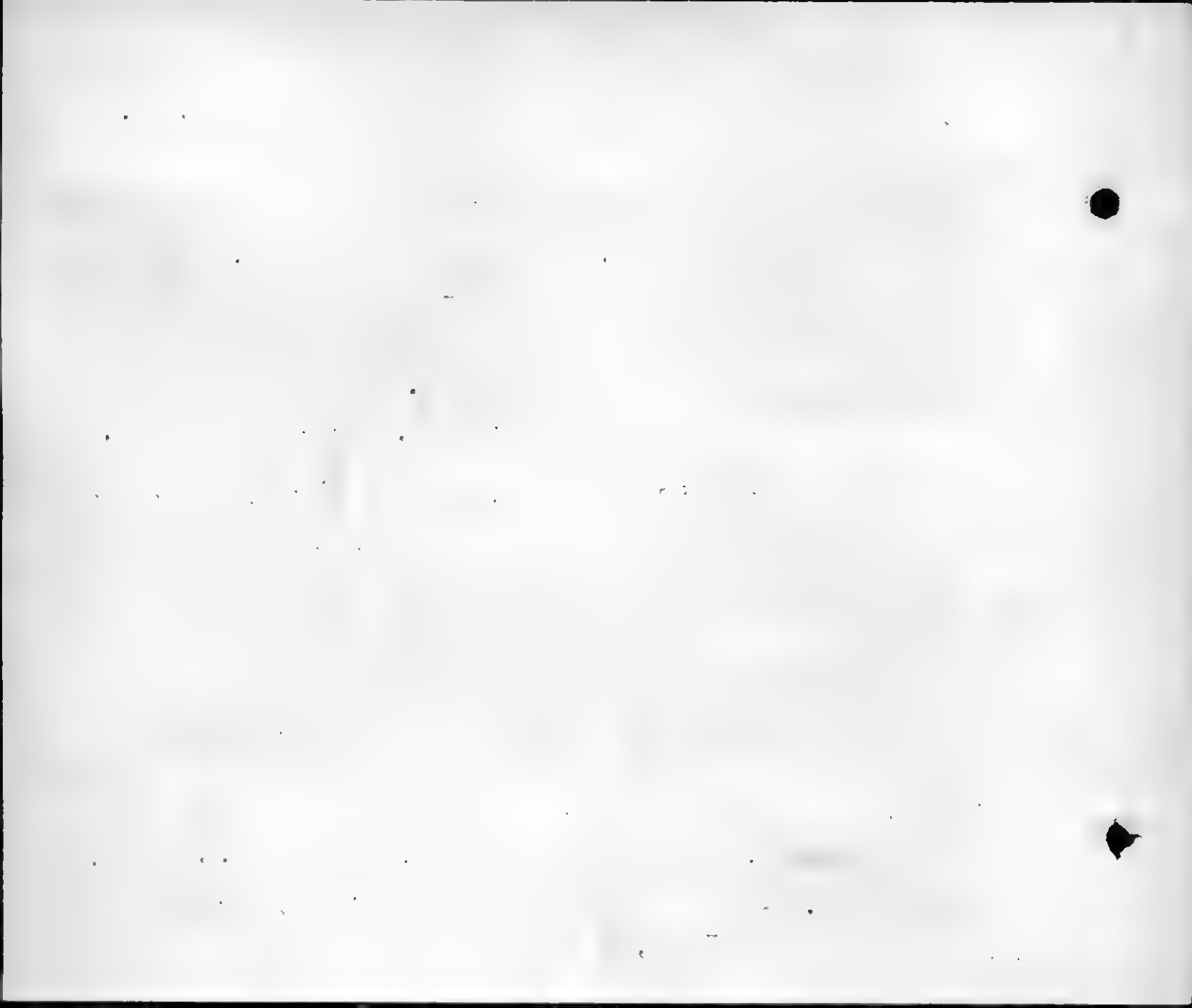
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00968

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Morningside 19	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 211- Randolph Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last BRAWNER		4. DATE OF DEATH Month Jan. Day 22 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26- 1892
9. AGE (In years last birthday) yrs 69		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Andrews Airforce Base	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Albert Brawner		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs Virginia C. Brawner		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO (b) Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Hypertensive arterio-sclerosis H.D. Acute Cerebro-Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 2-3 days 5-10 yrs 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 1954 to 22 Jan 19 62 that (I) (we) last saw the deceased alive on 22 19 62 and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sidney W. Lowry		22b. DATE SIGNED 1/22/62	
22c. PHYSICIAN'S NAME (Type) Sidney W. Lowry		22d. ADDRESS 7200-Marlboro Pike S.E. District Hgts Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 24- 62	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		25a. REC'D BY REGISTRAR Jan 23 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Tamm			

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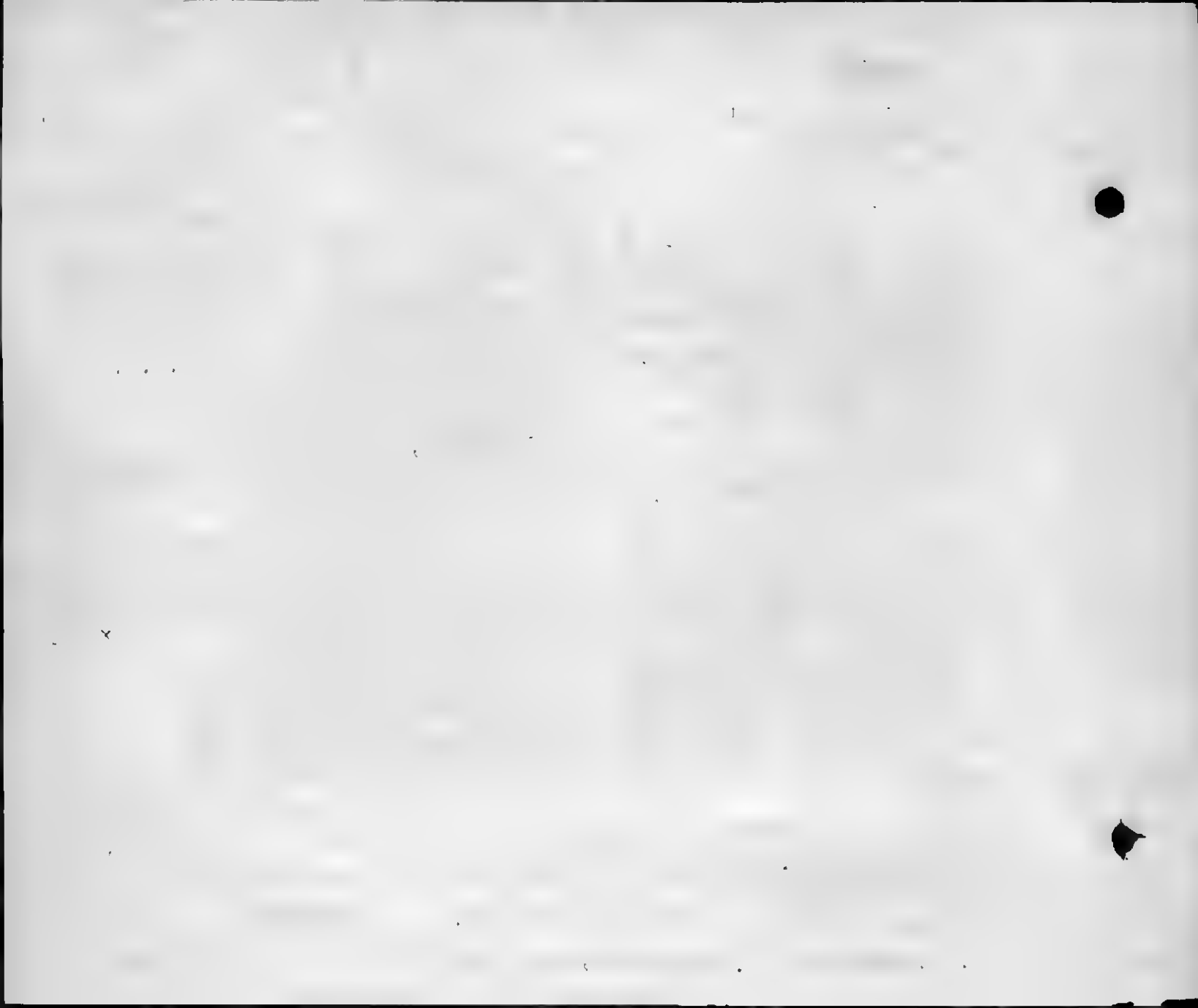
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you. Files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSMC
SM 9,60

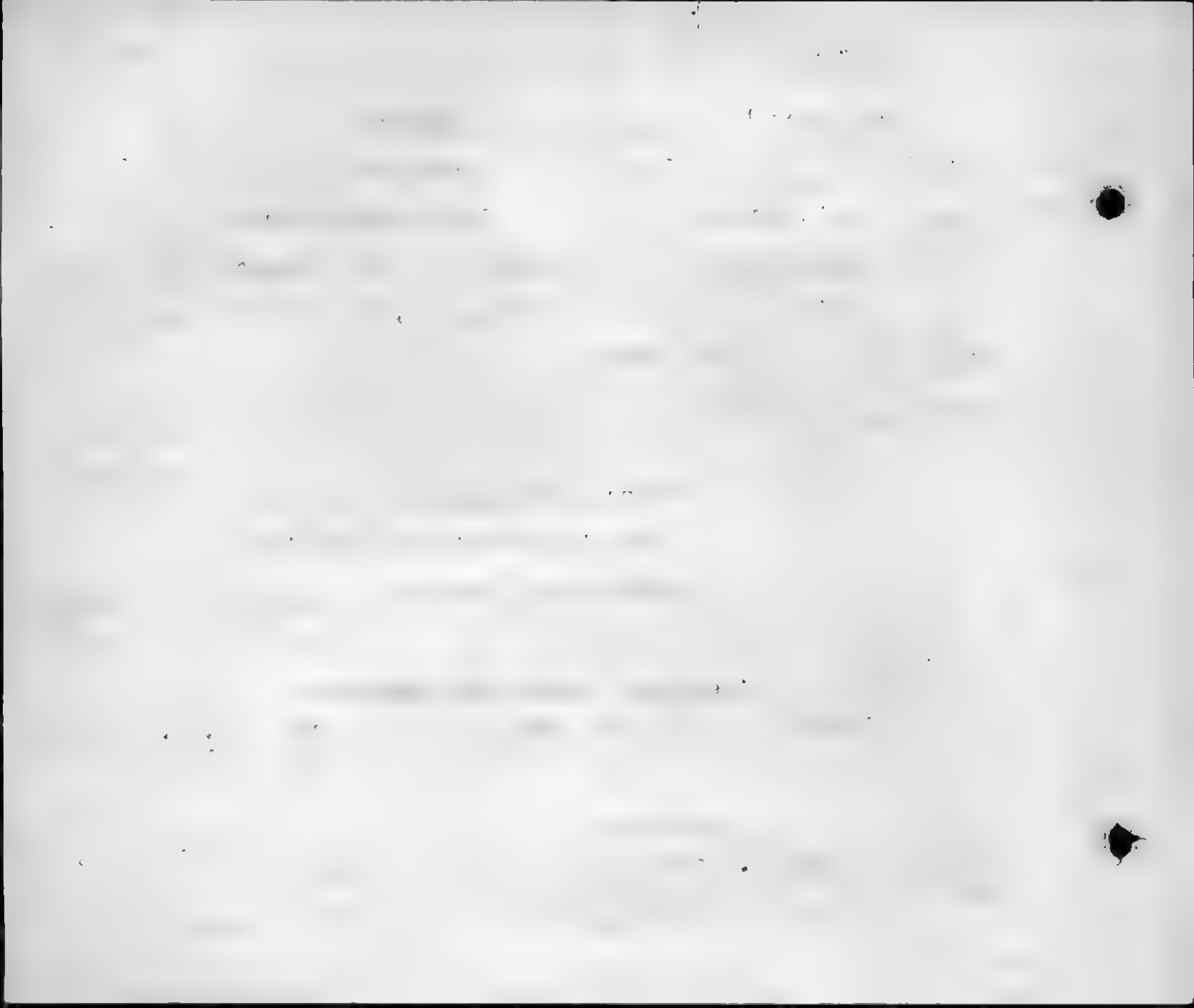
<div>Items 18-23 Film 306</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>00976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00969</div>													
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 3 mo						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1434 Kanawha Street						d. STREET ADDRESS 1434 Kanawha Street							
3. NAME OF DECEASED (Type or print) Myrle Hollycross Brener						4. DATE OF DEATH January 5 19 62							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1899		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Emerson Hollycross						14. MOTHER'S MAIDEN NAME Latham							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)						16. SOCIAL SECURITY NO. Al Brener, same as # 2							
17. INFORMANT Al Brener, same as # 2						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Acute barbiturate poisoning 871.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took excessive barbiturates									
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. 1-5 19 62				20d. INJURY OCCURRED At work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home					
				20f. (City or town) Hyattsville (County) F.G. (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE James I. Boyd M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/9/62		22c. NAME OF CEMETERY OR CREMATORY Forest Grove Cem.				22d. LOCATION (City, town, or country) (State) Plain City Ohio			
23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Maryland						24a. REC'D BY REGISTRAR JAN 9 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kram					

MEDICAL CERTIFICATION



VS. AISI
5M 9/60

<p>1. PLACE OF DEATH</p> <p>a. COUNTY Prince George's MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel</p> <p>c. LENGTH OF STAY IN lb 1 day</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rear 307 Main Street</p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission)</p> <p>a. STATE Maryland b. COUNTY _____</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore</p> <p>d. STREET ADDRESS 1824 Asquith Street</p>	
<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>f. DATE OF DEATH January 25 1962</p> <p>g. AGE (In years last birthday) 52 yrs. h. IF UNDER YEAR Months Days i. IF UNDER 24 HRS. Hours Min.</p>	
<p>3. NAME OF DECEASED (Type or print) Lawrence Brennan</p> <p>5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH February 7, 1909</p>		<p>9. AGE (In years last birthday) 52 yrs. h. IF UNDER YEAR Months Days i. IF UNDER 24 HRS. Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom</p> <p>10b. KIND OF BUSINESS OR INDUSTRY Race track</p>		<p>11. BIRTHPLACE (State or foreign country) unknown</p> <p>12. CITIZEN OF WHAT COUNTRY? unknown</p>	
<p>13. FATHER'S NAME unknown</p>		<p>14. MOTHER'S MAIDEN NAME unknown</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown</p>		<p>16. SOCIAL SECURITY NO. unknown 17. INFORMANT Address Police Investigation, Berger Point,</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) Exposure to cold</p> <p>(b) Fatty infiltration of the liver</p> <p>(c) Adhesive pericarditis</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. e) Slept out in an old automobile</p>			
<p>INTERVAL BETWEEN ONSET AND DEATH _____</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Parking lot</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 1/25/62</p>		<p>20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel P. G. Md</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE James I. Boyd</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>EXAMINER'S NAME (Type) James I. Boyd</p>		<p>DATE SIGNED January 26, 1962</p>	
<p>22a. REMOVAL (Specify) 3-9-62</p>		<p>22b. NAME OF CEMETERY OR CREMATORY Med. School Baltimore, Md.</p>	
<p>22c. LOCATION (City, town, or county) Baltimore, Md.</p>		<p>22d. LOCATION (City, town, or county) Baltimore, Md.</p>	
<p>23. FUNERAL DIRECTOR</p>		<p>24a. REC'D BY REG. STRAR MAR 12 '62 24b. REGISTRAR'S SIGNATURE Eugene L. House</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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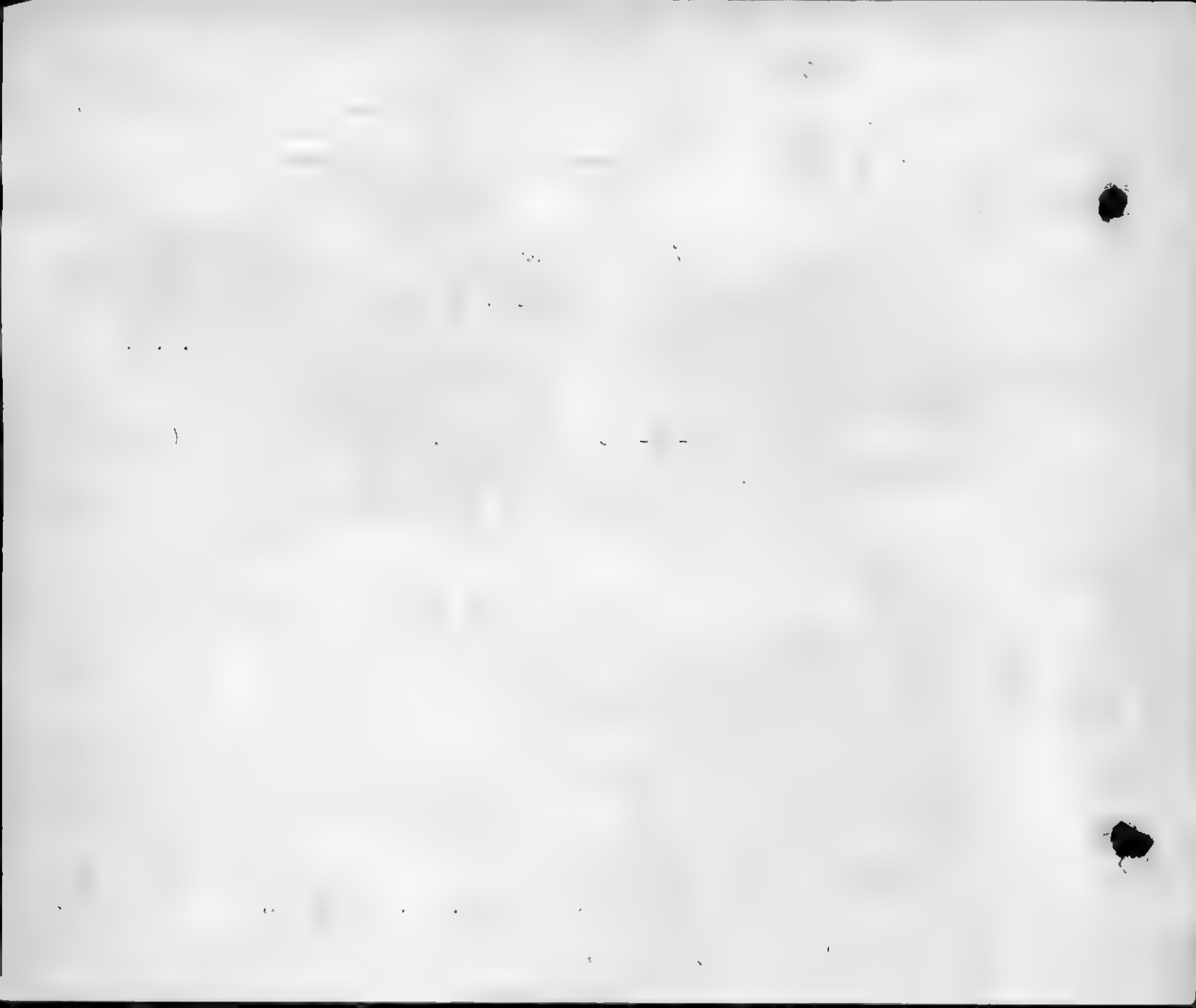
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00978

00978

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kentland c. LENGTH OF STAY IN b. 8 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7646 Goodland Drive		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kentland d. STREET ADDRESS 7646 Goodland Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY First Horton Middle BREWER Last 4. DATE OF DEATH JAN 25, 1962 Month JAN Day 25 Year 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 3, 1902 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Merchant Terminal Corporation 11. BIRTHPLACE (County & State, or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Brewer		14. MOTHER'S MAIDEN NAME Lela Middleton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-3335 17. INFORMANT Dorothy E. Brewer Same as #2 (Wife) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) several yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan 23, 1962 to Jan 25, 1962 that (2) (we) last saw the deceased alive on Jan 23, 1962 and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William D. Rossen M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/62	
23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Mem. Pk.		23d. LOCATION (City, town or county) (State) Elkridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR JAN 26 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kinross	



may be released by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

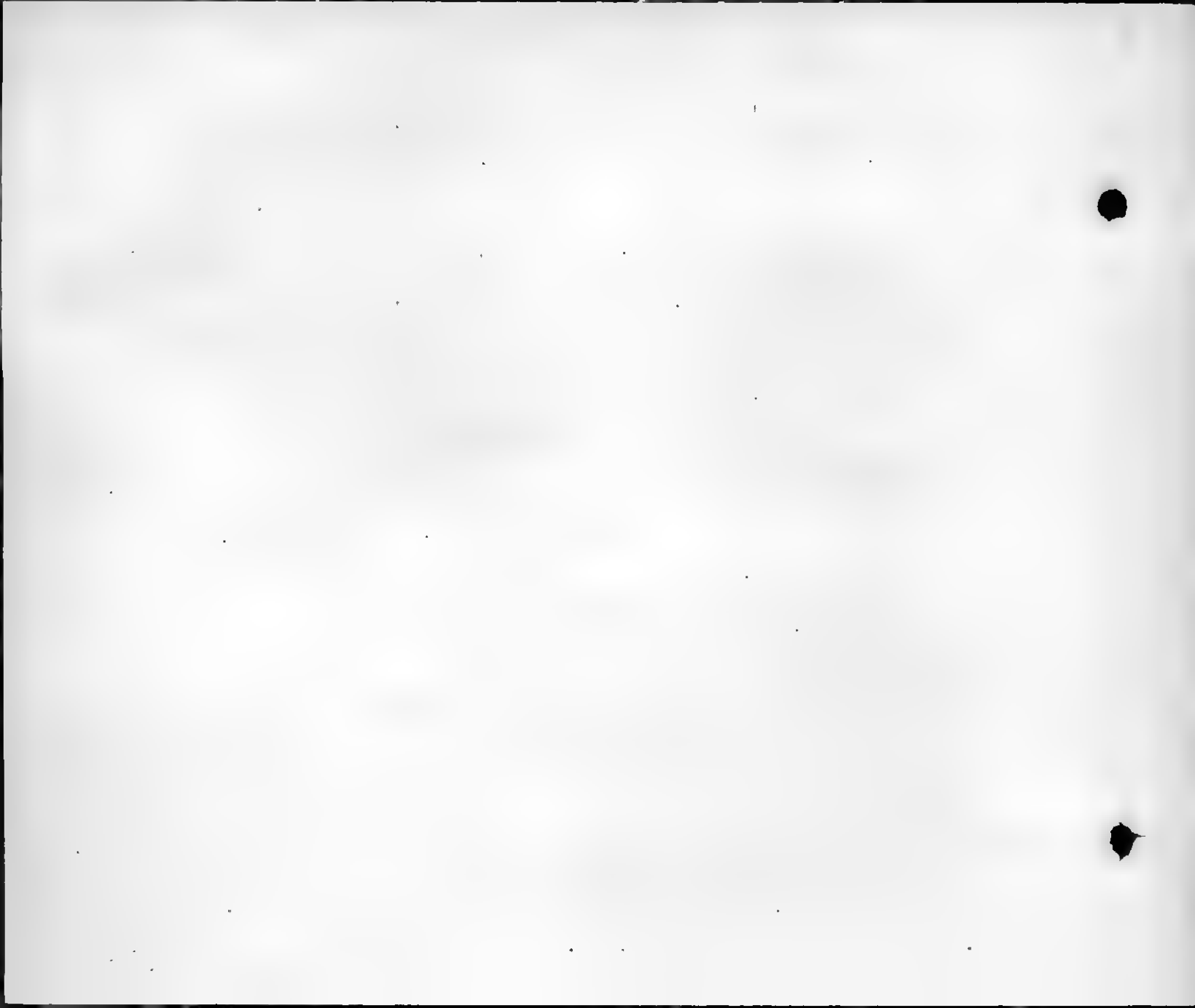
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

00979

CERTIFICATE OF DEATH

00971

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paint Branch Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALMEDA First C. Middle BRIGGS Last		4. DATE OF DEATH Month January Day 26 , Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870 9. AGE (In years last birthday) 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Hoflund		14. MOTHER'S MAIDEN NAME Christine Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs Donald Harvey Address Riverdale Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial Pneumonia Lt 2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease & Failure DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Fractured Left Hip 11-30-61 - Semility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-22 1961 to 1-26 1962 that (I) (we) last saw the deceased alive on 1-25 1962, and that death occurred at 8:00 AM , from the causes and on the date stated above			
22a. SIGNATURE Waldo B. Moyers M D		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Waldo B. Moyers		22d. ADDRESS 3503 Perry St. Mt. Rainier Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 29, 1962	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town, or county) (State) Suitland Md.
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR FEB 1 '62 DATE	25b. REGISTRAR'S SIGNATURE C. Edgar S. Kneer



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00980

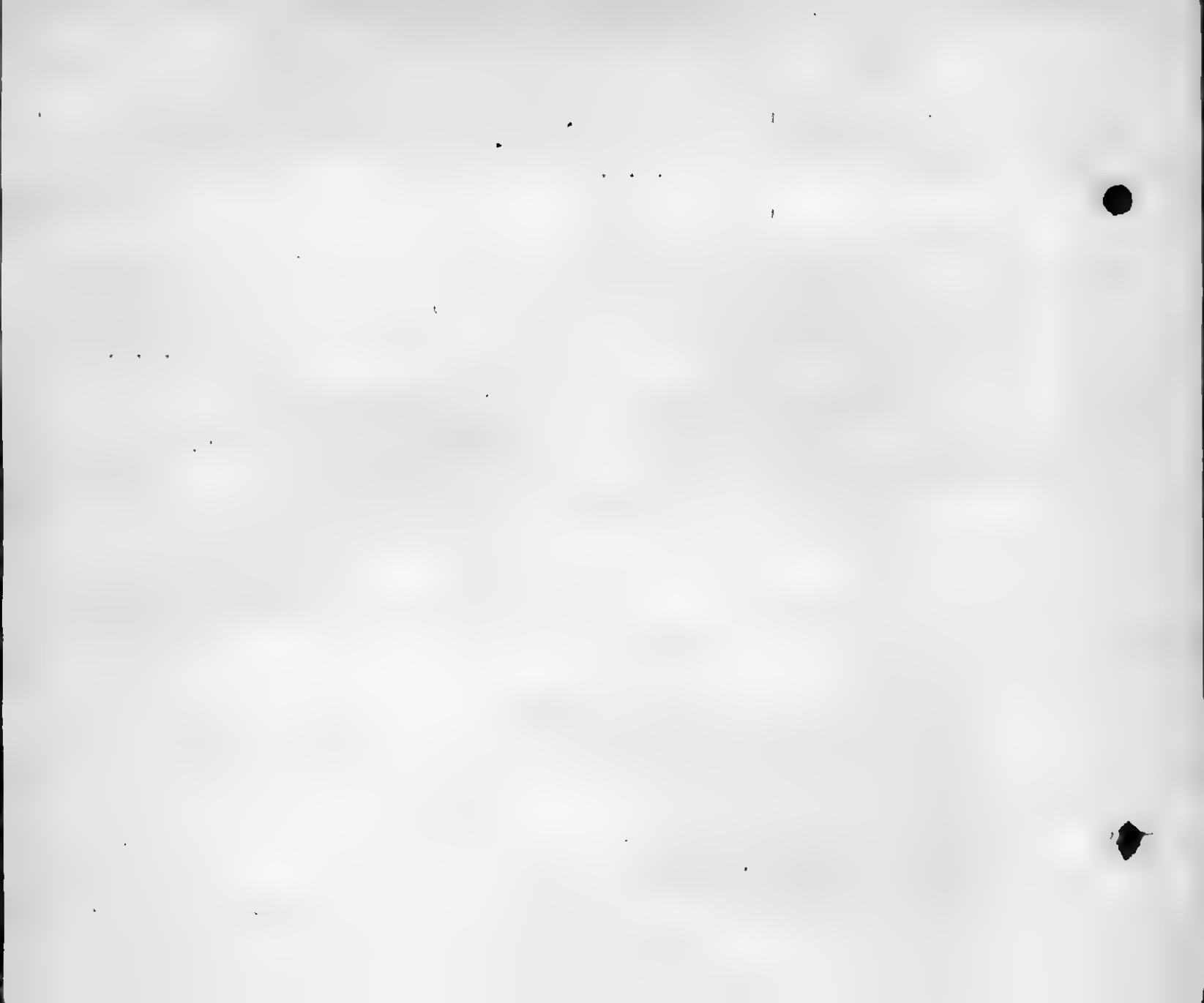
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00972

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Dept. for instructions. The certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>148 7th Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daniel Walker Brookman Jr</u>		4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1961</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>15</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Walker Brookman Sr</u>		14. MOTHER'S MAIDEN NAME <u>Carol Jeanette Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daniel Walker Brookman Sr. same as #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a);			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)	
20g. (State)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/22/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>JAN 19 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina S. Kraus</u>		24c. DATE	

2076273166



12
FOR STATE
HEALTH DEPT.

TO DEFEND: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please place the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

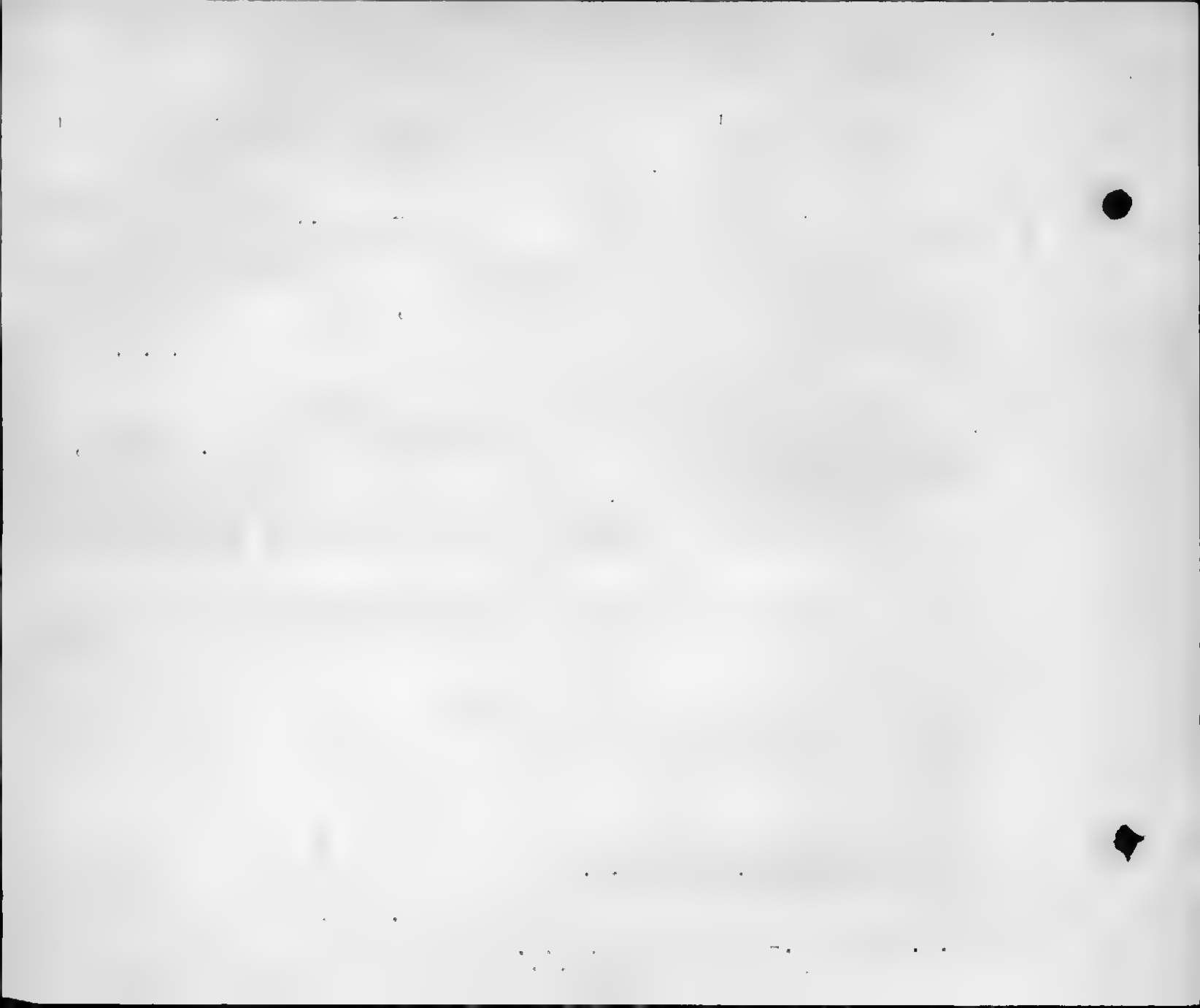
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00981

00973

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3804 - 38th., Avenue			
3. NAME OF DECEASED (Type or print) Anna Mae Brown				4. DATE OF DEATH January 9, 1962			
5. SEX Female				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH October 15, 1907 54 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Marion Smith				14. MOTHER'S MAIDEN NAME Anna Gabriel Fuse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Helen Mildred Hollidge				Address 3109 Quenns Chape Mt. Rainier, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute congestive heart Failure							
Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular renal disease							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 1/9/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 1/12/62			
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				22d. LOCATION (City, town, or country) Ft. Myer, Virginia			
23. FUNERAL DIRECTOR The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE JAN 11 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

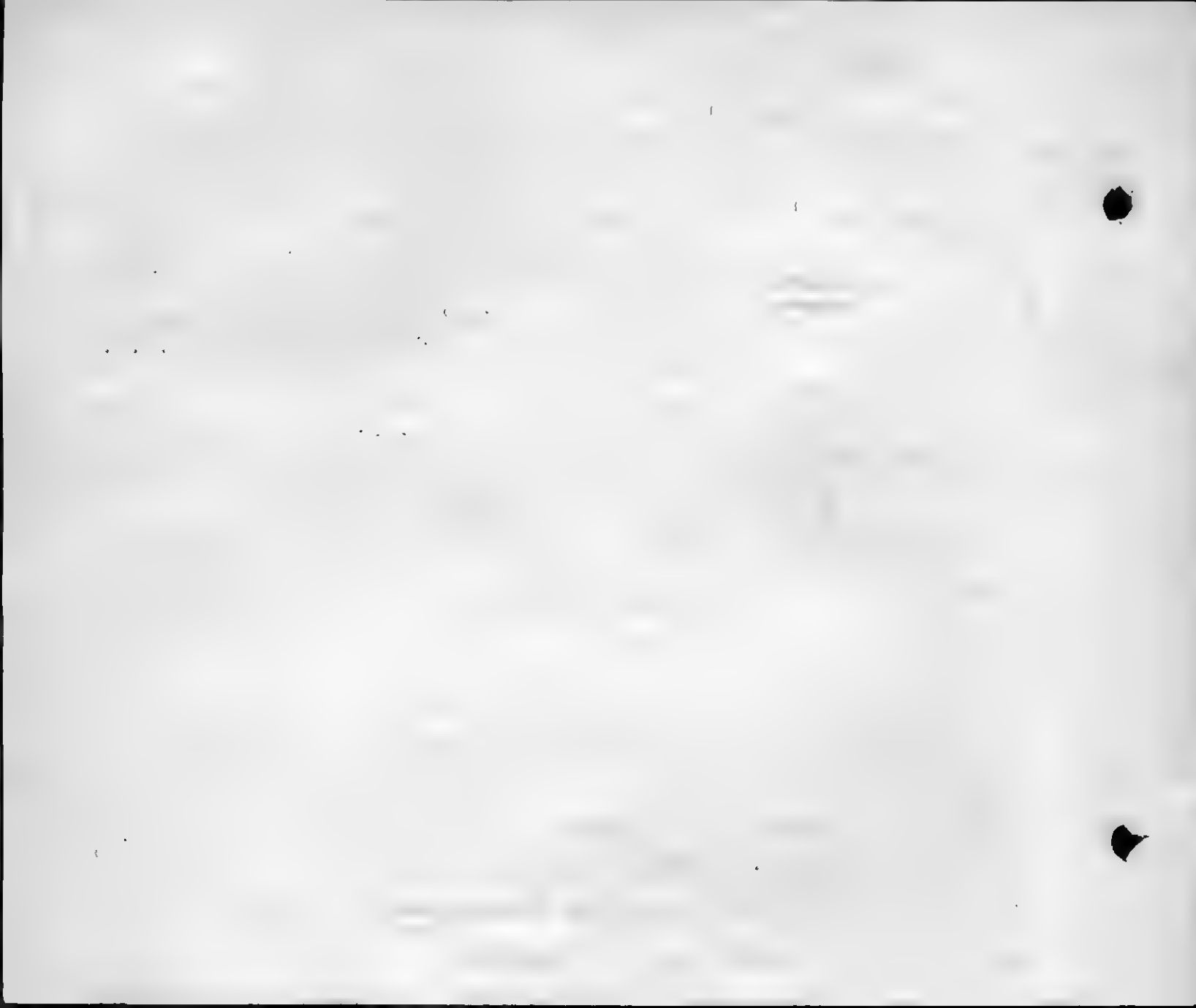
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2

2

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>00982</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00971</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>b. COUNTY</div> </div> </div>													
<div> <div>Prince George's</div> <div>MARYLAND</div> </div>				<div> <div>Maryland</div> <div>Prince George's</div> </div>									
<div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>c. LENGTH OF STAY IN 1b</div> </div>				<div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>d. STREET ADDRESS</div> </div>									
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Prince George's General Hospital</div> </div>				<div> <div>5700 Sheriff Road</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>					
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First Middle Last</div> </div>				<div> <div>4. DATE OF DEATH</div> <div>Month Day Year</div> </div>				<div> <div>January 18, 19 62</div> </div>					
<div> <div>5. SEX</div> <div>Female</div> </div>		<div> <div>6. COLOR OF SKIN</div> <div>White</div> </div>		<div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>Aug. 4, 1919</div> </div>		<div> <div>9. AGE (In years last birthday)</div> <div>42 yrs.</div> </div>		<div> <div>IF UNDER 1 YEAR</div> <div>Months Days</div> </div>		<div> <div>IF UNDER 24 HRS.</div> <div>Hours Min.</div> </div>	
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>House Wife</div> </div>				<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Own Home</div> </div>		<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>District of Columbia</div> </div>		<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>					
<div> <div>13. FATHER'S NAME</div> <div>Ernest Spence</div> </div>						<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Lilly Mae Walters</div> </div>							
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)</div> <div>No</div> </div>				<div> <div>16. SOCIAL SECURITY NO.</div> </div>		<div> <div>17. INFORMANT</div> <div>Raymond Nierrie Coleman</div> </div>		<div> <div>Address</div> <div>1010 Addison Rd Fairmont Hts</div> </div>					
<div> <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</div> <div>1. 2. 1 DUE TO</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>2. 1 DUE TO</div> <div>3. 1 DUE TO</div> <div>COR PULMONALE</div> <div>PULMONARY TUBERCULOSIS</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>													
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</div> <div>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.</div> <div>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town) (County) (State)</div> </div>													
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div> <div>James I. Boyd</div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>DATE SIGNED</div> <div>January 18, 1962</div> </div>													
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>22b. DATE THEREOF</div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>22d. LOCATION (City, town, or country, (State)</div> </div>													
<div> <div>BURIAL</div> <div>1-23-62</div> <div>LINCOLN MEMORIAL SUITLAND, MD.</div> </div>													
<div> <div>23. FUNERAL DIRECTOR</div> <div>24a. REC'D BY REGISTRAR</div> <div>24b. REGISTRAR'S SIGNATURE</div> </div>													
<div> <div>MYRTLE K. ROLLINS 4339 HUNT PL. NE. DC</div> <div>JAN 22 '62</div> <div>James I. Boyd</div> </div>													



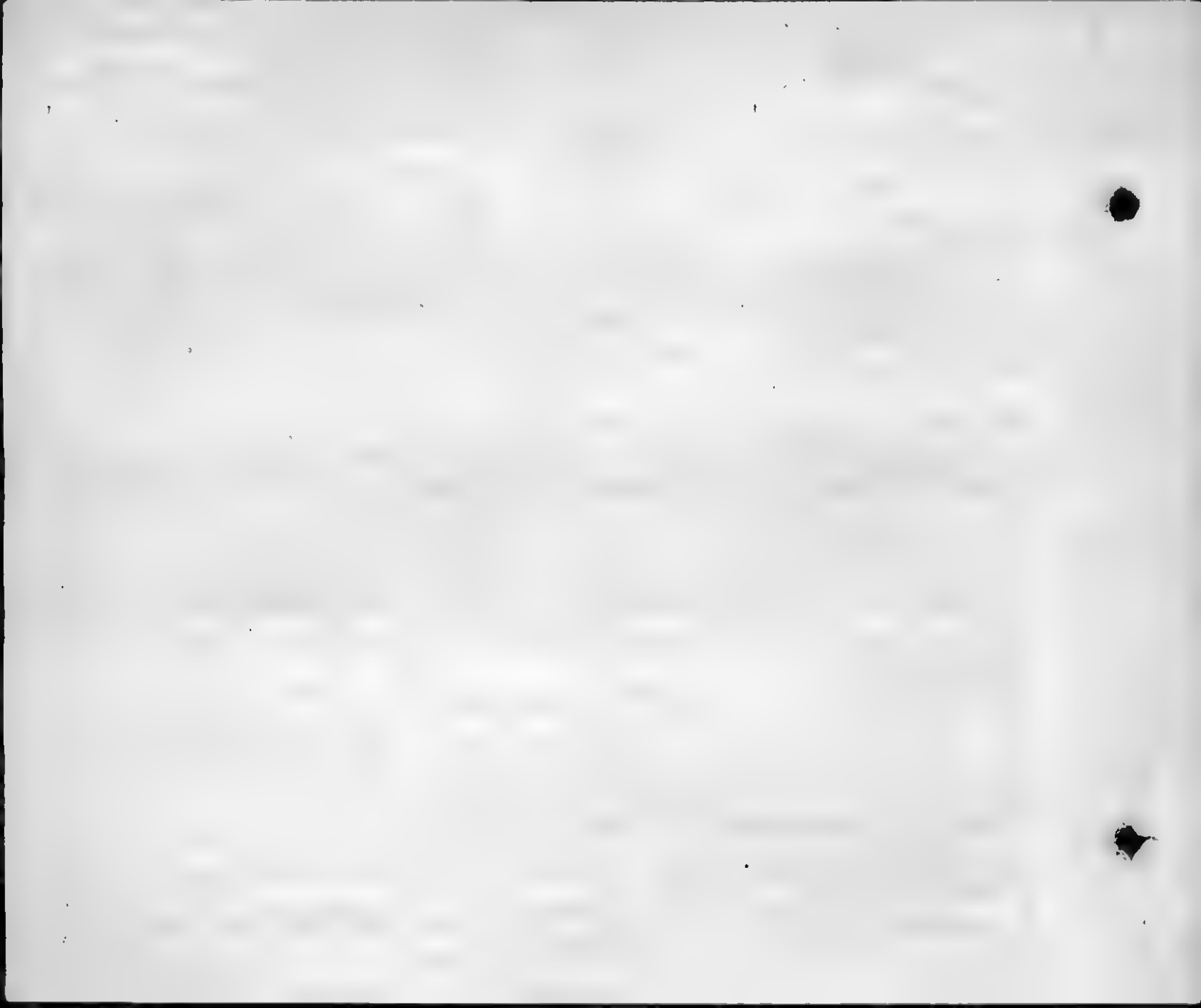
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
00983 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 011975

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brown c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marlboro Ritchie Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brown d. STREET ADDRESS Marlboro Ritchie Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank Charles Brown		4. DATE OF DEATH January 29 1962		5. SEX Male	
6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 1	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days	
13. FATHER'S NAME Alfred Edward Brown		14. MOTHER'S MAIDEN NAME Lucia Johnson		IF UNDER 24 HRS. Hours Min.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Alfred Edward Brown, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus due to congenital cyst in brain 7-11 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Resolving pneumonia, Congenital heart disease		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 29, 1962	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-2-62		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel	
22d. LOCATION (City, town, or county) Upper Marlboro Md					
23. FUNERAL DIRECTOR Henry S. Washington Sons 4925 New Ave NE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE FEB 5 '62					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

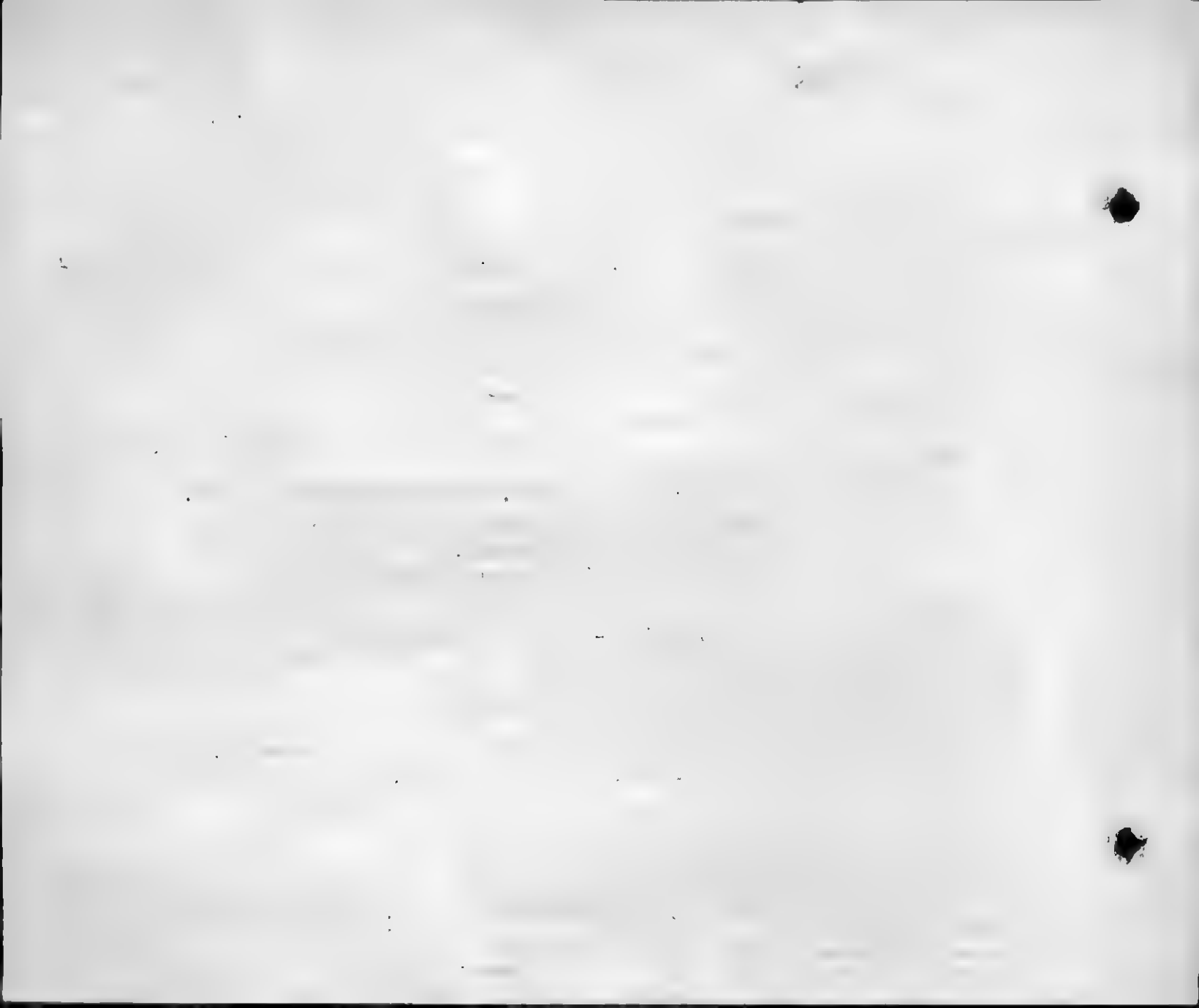
CERTIFICATE OF DEATH

00984

00976

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cedar Heights d. STREET ADDRESS 6418 J Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George F. Brown		4. DATE OF DEATH January 13 1962	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1884	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. 46-45-10000	
17. INFORMANT George F. Brown		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Hydrothorax. Congestive heart failure. (b) Old coronary occlusion with mural thrombus (c) Multiple pulmonary emboli. Coranary Arteriosclerotic Heart Disease	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis (left parieto-occipital lobe)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 12, 1961 to January 13, 1962, that (I) (we) last saw the deceased alive on January 13, 1962, and that death occurred at 3:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE R.D. Bauer M.D.		22b. DATE SIGNED 1-14-62	
22c. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.		22d. ADDRESS Prince Georges General Hospital, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-17-62	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington Son		25a. REC'D BY REGISTRAR DATE JAN 18 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Hanna		25c. ADDRESS 4925 Neane Ave N.E.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

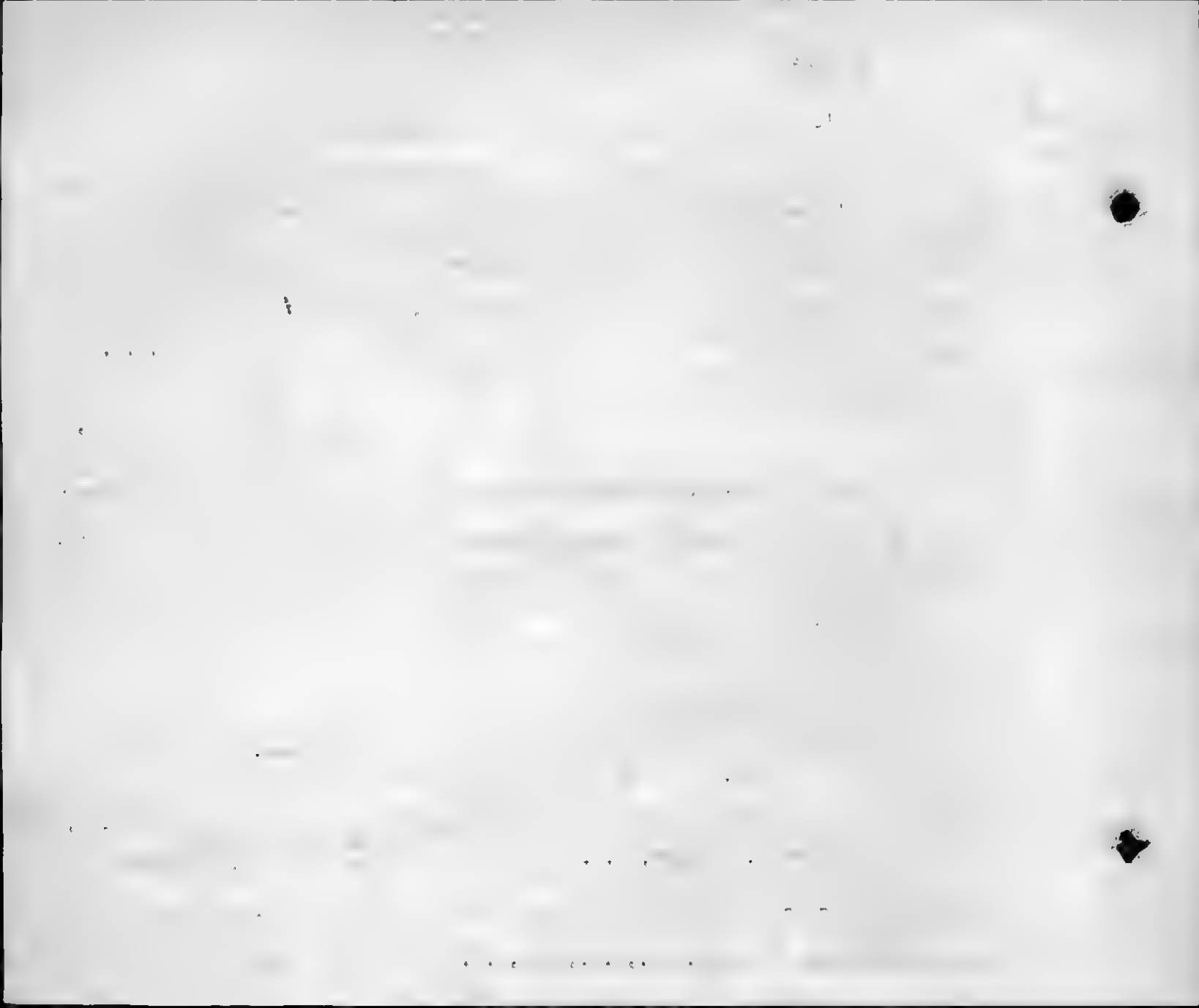
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00985

CERTIFICATE OF DEATH

00977

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3618 Cooper Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond Henry Browne</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 4, 1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Floyd Grant Browne</u>		14. MOTHER'S MAIDEN NAME <u>Susan ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 2nd LUW</u>		16. SOCIAL SECURITY NO. <u>2nd LUW</u>	
17. INFORMANT <u>Agnes Elizabeth Browne</u>		Address <u>Hyattsville, Md</u> <u>3618 Cooper Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>425-1</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Left Illiac Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1954</u> , to <u>Jan. 7, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 7, 1962</u> , and that death occurred at <u>8P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles C. Hageage</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles C. Hageage, M.D.</u>		22b. DATE SIGNED <u>Jan. 8, 1962</u>	
22d. ADDRESS <u>3308 Perry Street</u> <u>Mount Rainier, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-10-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2

00986

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00978

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Md</u>	
c. LENGTH OF STAY IN 1b <u>24 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4714 Sheridan Street</u>		d. STREET ADDRESS <u>14714 - Sheridan St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>LAWRENCE</u> Middle <u>BUCKLEY</u> Last		4. DATE OF DEATH <u>Jan 5</u> 19 <u>62</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1904</u>
9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attorney (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Deft. Magistrate</u>	
11. BIRTHPLACE (State or foreign country) <u>Bridgeport Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES BUCKLEY</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE CRONIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. J. Buckley</u> Address <u>4714 - Sheridan St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cirrhosis of liver & ascites</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that (I) (the hospital) attended the deceased from <u>Dec 15, 1961</u> to <u>Jan 5, 1962</u> , that (I) (we) last saw the deceased alive on <u>1/5</u> 19 <u>62</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ignatius Rutkowski</u> M.D.		22b. DATE SIGNED <u>1/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>IGNATIUS RUTKOSKI, MD</u>		22d. ADDRESS <u>1819 - G St. NW Washington D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/9/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City, town, or county) <u>Washington D. C.</u> (State) <u></u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>

MEDICAL CERTIFICATION

W.D.L.

CERTIFICATE OF DEATH

Reg. Dist. No. 111929

00987

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEABROOK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9608 FRANKLIN AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>MAY</u> Last <u>BURCH</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>5</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 19 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNKNOWN - PARKER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS EVELYN BRYAN</u> Address <u>2609 NEWTON ST. N.E. WASHINGTON, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>42:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>00</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1954</u> to <u>1/5 1962</u> that I last saw the deceased alive on <u>1/3/1962</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4410 74th Ave</u> DATE SIGNED <u>1/5/62</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>F. E. Musser, MD Hyattsville, Md</u> PHYSICIAN'S NAME (Type) <u>F. E. Musser, MD Hyattsville, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN-9-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO. RIVERDALE, MD</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 1962</u>		24b. REGISTRAR'S SIGNATURE <u>Cornelius E. Tuma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00988
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b 2 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address, ADSACORDA CHEVERLY CONVALESCENT HOME)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE VA. b. COUNTY North Cumberland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALLAO d. STREET ADDRESS R.F.D. # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) INEZ 4. DATE OF DEATH BURGESS Month JANUARY Day 25 Year 1962		5. SEX FEMALE 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH SEPT. 23, 1882 9. AGE (In years last birthday) 79 yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) White Stone, Va. 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Burgess 14. MOTHER'S MAIDEN NAME Eliza Billups 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT MRS. H.A. LEUSENKAMP 810 GIST AVE SILVER SPRING, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 mos 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Nov , 19 61 , to 1/25 , 19 62 , that (I) (we) last saw the deceased alive on 1/25 , 19 62 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Norman Donat Comeau 22c. PHYSICIAN'S NAME (Type) Norman Donat Comeau 22b. DATE SIGNED 1/25/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 3503 Penny St Mt Rainier Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 28 Jan 62 23c. NAME OF CEMETERY OR CREMATORY Hatfield E. RSON Cem. 23d. LOCATION (City, town or county) (State) Hypocanth Va	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 3004 H St. NE 25a. REC'D BY REGISTRAR JAN 29 1962 25b. REGISTRAR'S SIGNATURE William L. Thomas			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01081

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
c. LENGTH OF STAY IN TB D.O.A.		d. STREET ADDRESS 6018 Sheriff Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Elaine Burroughs		4. DATE OF DEATH Month Day Year January 24 1962	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1890	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Edward Broome		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-10-2234	
17. INFORMANT Bernard Earlington Burrows		Address 1037 Brantly Baltimore, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (b) cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED January 24, 1962	
EXAMINER'S NAME (Type) James I. Boyd		Address (Street, city, town, or county) Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/62	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Arthur S. Thomas		24a. REC'D BY REGISTRAR DATE JAN 29 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		30 H Street, N.E. D.C.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00990

00982

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>R.F.D. Box 1492</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry Jones</u>		4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1962</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-62</u>		9. AGE (In years last birthday) <u>12</u> IF UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <u>Prince George, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Melvin Thomas (or Clark)</u>			14. MOTHER'S MAIDEN NAME <u>Marie Butler</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>754</u> DUE TO (b) <u>Atresia of the Tricusphide Valve</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 11</u> , 19 <u>62</u> , to <u>Jan. 23</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Jan. 23</u> , 19 <u>62</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Miles A. Jansa</u>		22b. DATE SIGNED <u>Jan. 23, 1962</u>	22c. PHYSICIAN'S NAME (Type) <u>Dr. Miles A. Jansa</u>				
22d. ADDRESS <u>7403 Varnum St., Landover Hills, Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince Gen. Gen. Hospital</u>			
23d. LOCATION (City, town or county) <u>Cheverly, Md.</u>		23e. REC'D BY REGISTRAR <u>FEB 6 '62</u>					
23f. REGISTRAR'S SIGNATURE <u>Colbert S. Thomas</u>		23g. DATE <u>FEB 6 '62</u>					

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Paper 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Paper 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00991

Items 23 Film G505 1/15/62 iwk

00983

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY - ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN IL 19 days		d. STREET ADDRESS 3808 13th St., N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydia A. Butler		4. DATE OF DEATH 1 4 19 62	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/1880	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Curtis		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frances E. Smith, daughter, 3808 13th St., N.W. Washington, D. C. decedent		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident with left hemiparalysis DUE TO (b) - DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced; generalized arteriosclerosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 12/16 1962, to 1/4 1962		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 12/16 1962, to 1/4 1962 that (I) (we) last saw the deceased alive on 1/4 1962, and that death occurred at A.M., from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 1/4/62	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 1/8/62	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) Bushwood, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Maittengley Luv. Home, Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE JAN 10 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00992

CERTIFICATE OF DEATH

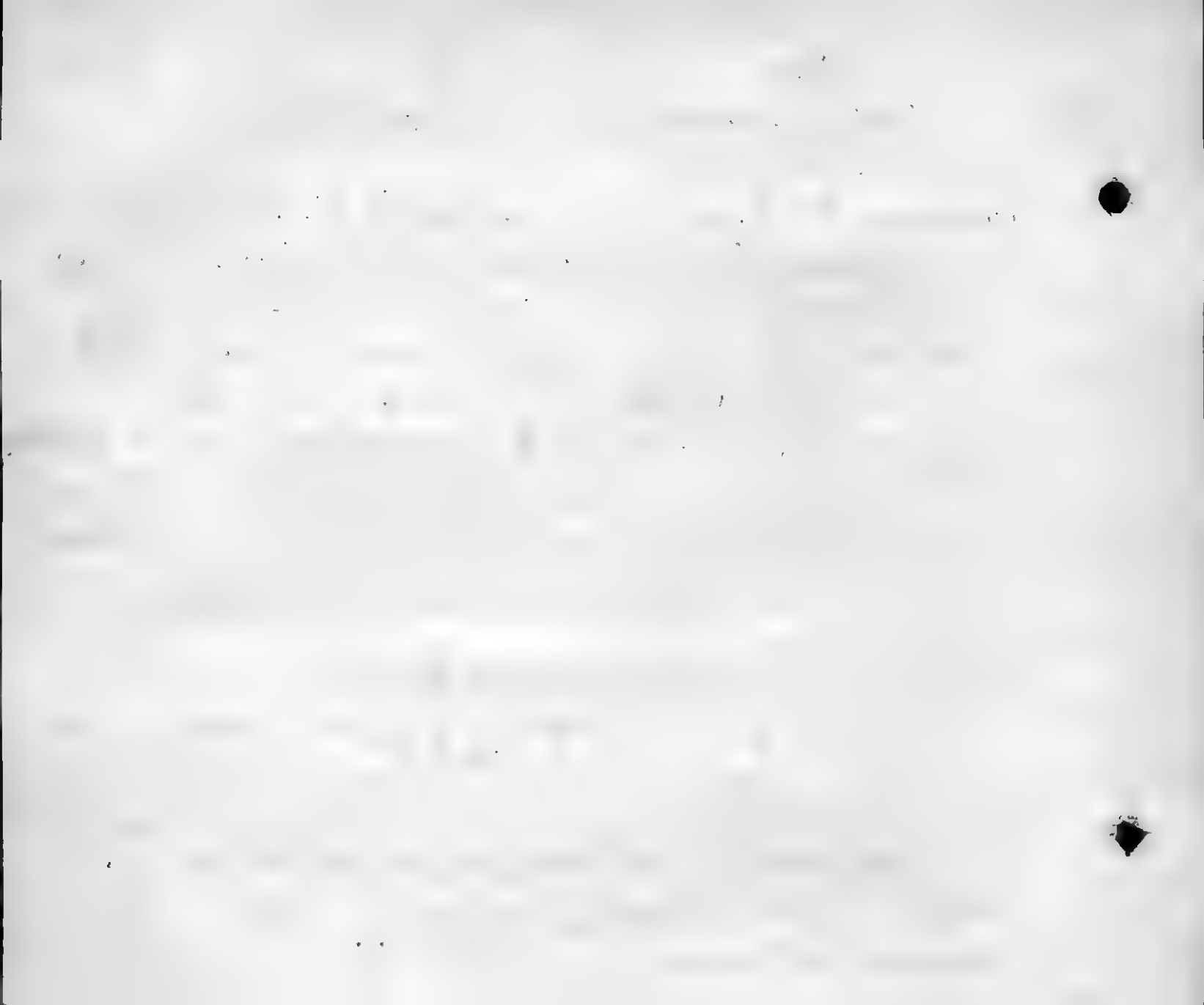
100984

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANDREWS AIR BASE Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DIST OF Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x5 d. STREET ADDRESS 6926 9th St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN O CABIGAS 5. SEX M 6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DATE OF BIRTH JAN 22 39 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 22 yrs. 9. AGE (In years last birthday) 22 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT 10b. KIND OF BUSINESS OR INDUSTRY PHILLIPINE ISLANDS 12. CITIZEN OF WHAT COUNTRY? USA		11. BIRTHPLACE (County & State, or foreign country) PHILLIPINE ISLANDS 14. MOTHER'S MAIDEN NAME MARIA CARIDAD	
13. FATHER'S NAME OSMUNDO CABIGAS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES OCT 1 1961 16. SOCIAL SECURITY NO. 218-38-569 17. INFORMANT (CWO) Leo Cleary 113 TAX F6 TEL		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (b) MULTIPLE INTERNAL INJURIES, INCL. CRUSHED CHEST (a), stating the underlying cause last. (c) TRAUMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) WHILE Erecting CRASH BARRIER HIT BY JET PLANE 20c. TIME OF INJURY Month, Day, Year 4th JAN 1962 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Airplane Runway Andrews AFB P.G. MD. 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that (I) (th's hospital) attended the deceased from 8 Jan 62, 19 to 8 JAN 1962, and that death occurred at 1650am from the causes and on the date stated above. 22a. SIGNATURE RUFUS F STANLEY JR. M.D. 22c. PHYSICIAN'S NAME (Type) RUFUS F STANLEY JR, Capt USAF MC USAF HOSP ANDREWS AIR FORCE BASE, MD 22b. DATE SIGNED 8 Jan 62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 1/12/62 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY 23d. LOCATION (City, town or county) ARL VA		24. FUNERAL DIRECTOR'S SIGNATURE W. J. Hunterman & Son ADDRESS 5732 GEORGIA AVE N.W. DATE JAN 11 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00985

00993

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>4314 Sheridan St. University park</u> b. COUNTY <u>md</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>64</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MADISON MANOR Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>ARLIE</u> Last <u>CALLAHAN</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telegraph Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Callahan</u>				14. MOTHER'S MAIDEN NAME <u>Ellan Sparks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>332X</u> DUE TO (b) <u>Hypostatic condition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 month</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis, multiple</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>61</u> , to <u>1-3</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-2</u> , 19 <u>62</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald C. Edgren</u> M D				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>1-3-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGREN</u>				22d. ADDRESS <u>3509 East-West Highway Hyattsville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/5/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 5 '62</u> 25b. REGISTRAR'S SIGNATURE <u>C. E. S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00994

00986

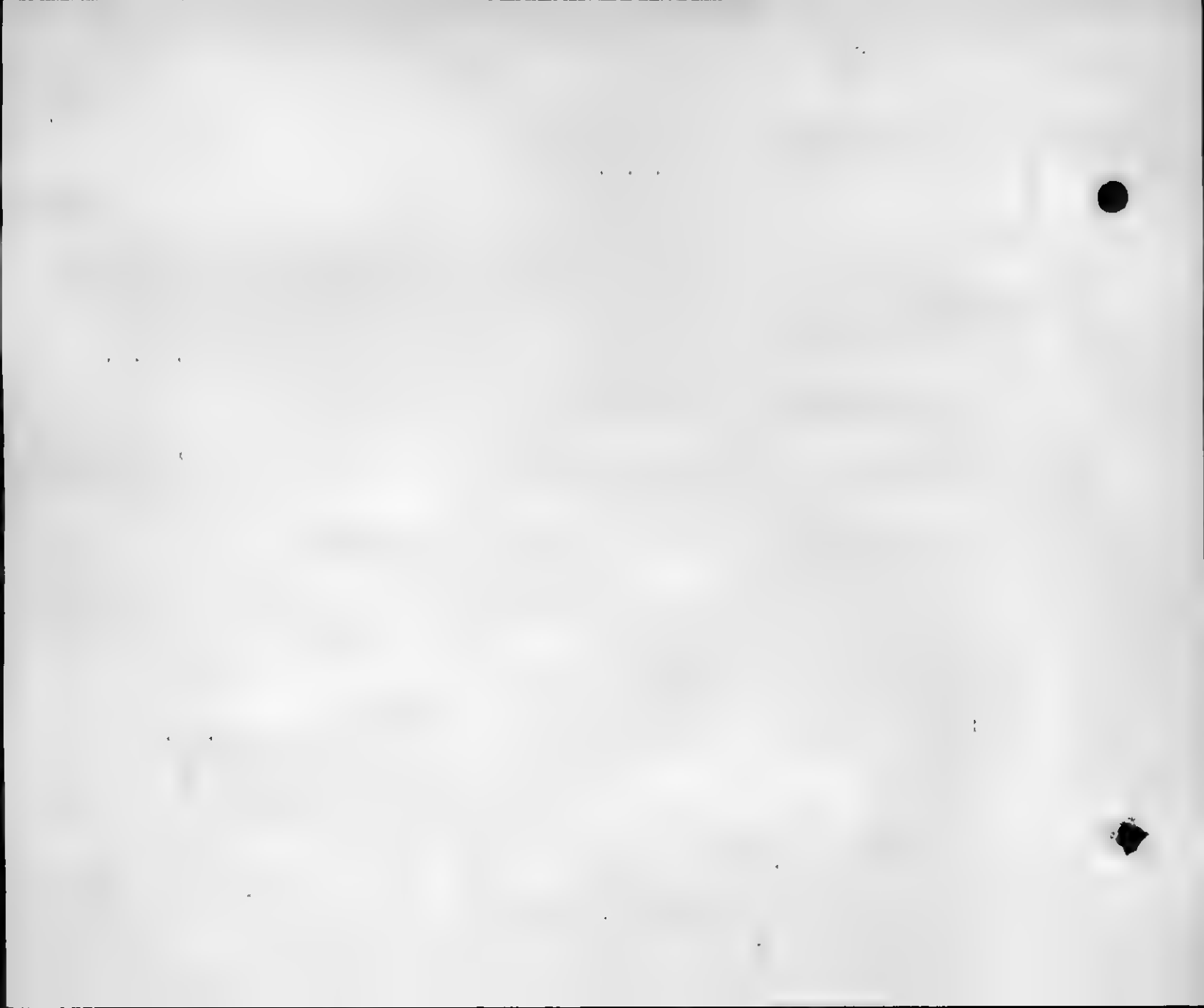
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN IB 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS Washington 47X 800 49th Place, N.E.	
3. NAME OF DECEASED (Type or print) Betty - Cary		4. DATE OF DEATH 1 29 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1859?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Va.	
13. FATHER'S NAME Jim Taylor		14. MOTHER'S MAIDEN NAME Jennie Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli, left lung 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerated thrombus, right atrium DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonitis, right; hypertensive and arteriosclerotic cardiovascular disease; cerebral vascular accident with left hemiparesis		INTERVAL BETWEEN ONSET AND DEATH 1 day unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/23/1962 to 1/29/1962, that (I) (we) last saw the deceased alive on 1/29/1962, and that death occurred at 11:43 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 1/29/1962	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-62	
23c. NAME OF CEMETERY OR CREMATORY Belmont		23d. LOCATION (City, town or county) (State) Ross Mill, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE M. B. Brown		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS: Queen Frederick by, Va		DATE FEB 1 '62	



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YS. A15ME
5M 9.60

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Franca Castle		4. DATE OF DEATH Month Day Year January 30 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1931
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Mon'ths Days 30 1	
11. IF UNDER 24 HRS. Hours M.n. 30 1		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Neri Battaglini		14. MOTHER'S MAIDEN NAME Elaine Pilsen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Guy Wilkinson Stuart Castle, same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of the head (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot self in head		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1:45 p.m. 1/30 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Oxon Hill P. G. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/30/62	
Address (Street, city, town, or county)		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 2 1962	
22c. NAME OF CEMETERY OR CREMATORY ST BARNABAS		22d. LOCATION (City, town, or country) OXON HILL MD (State)	
23. FUNERAL DIRECTOR W.W. CHAMBERS & CO WASHINGTON DC		24a. REC'D BY REGISTRAR FEB 5 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanks		DATE	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

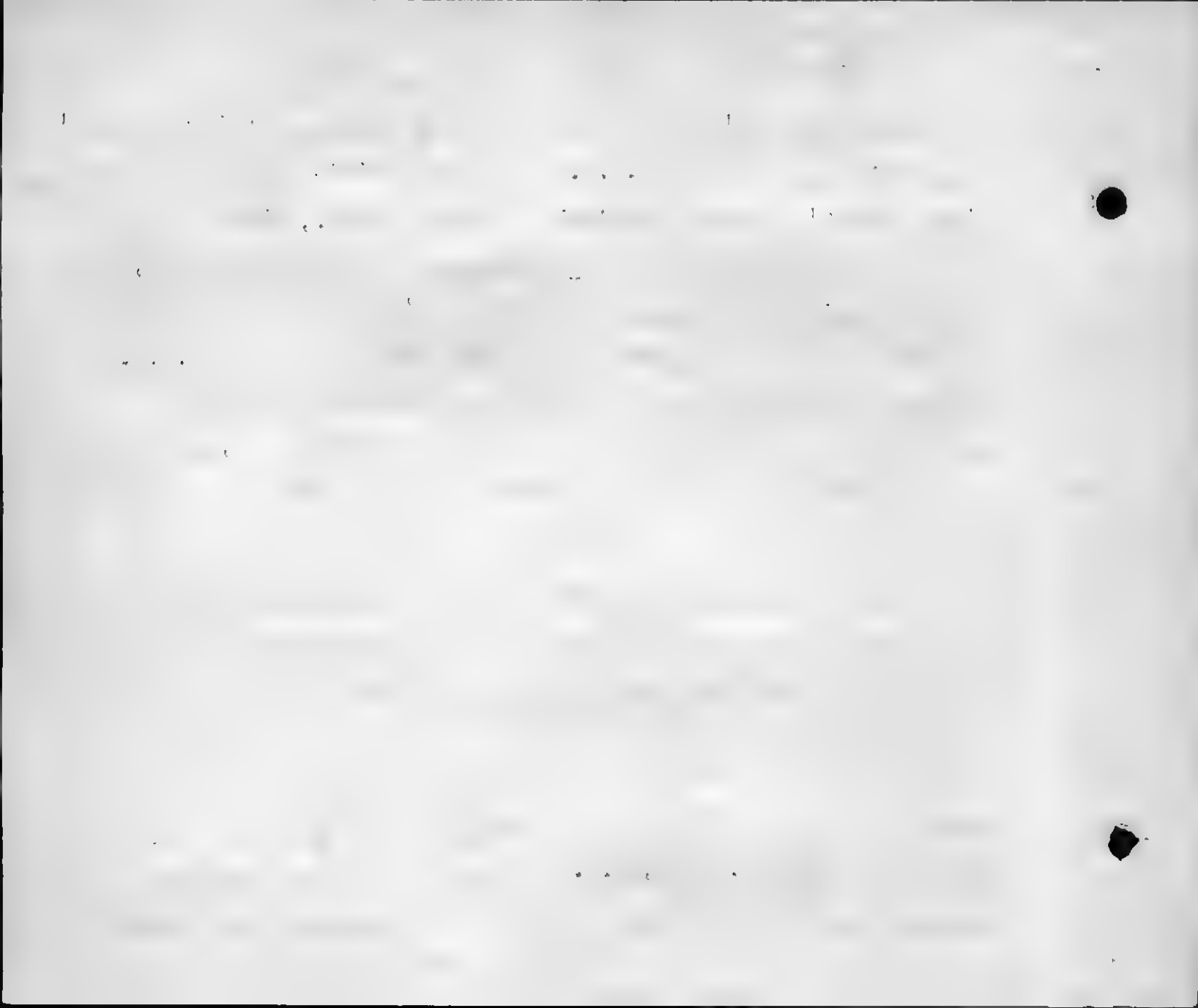
00938

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY in lb D.O.A.		d. STREET ADDRESS 4904 - 40th., Place	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			
3. NAME OF DECEASED (Type or print) Donald Lee Chavers		4. DATE OF DEATH January 24, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH August 22, 1961	
9. AGE (in years last birthday) 5 yrs. 2 months 2 days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willard Vinard C Chavers	
14. MOTHER'S MAIDEN NAME Ruth Caroline Kline		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Willard Vinard Chavers, same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 754 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Congenital heart disease, septal defect (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) 1-25-62		22b. DATE THEREOF 1-25-62	
22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School		22d. LOCATION (City, town, or country) (State) Baltimore Md.	
23. FUNERAL DIRECTOR Chambers		24a. REC'D BY REGISTRAR JAN 31 '62	
24b. REGISTRAR'S SIGNATURE Charles L. Thomas		DATE	

VS. A15ME
5M 9/60

Chambers 20971116

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the Director of Health, Baltimore, Maryland, for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20&21 Film 307 Maryland State Department of Health
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00089

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c. LENGTH OF STAY IN 1b 9 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3907 Longfellow Street

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 3907 Longfellow Street

3. NAME OF DECEASED (Type or print) Fannie Estelle Clark
4. DATE OF DEATH January 24, 1962
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH June 1, 1876
9. AGE (In years last birthday) 86 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nelson Ridgel 14. MOTHER'S MAIDEN NAME Susan Fenhagen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Myrtle Marie Kruger Name as #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (c)
DUE TO (e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: No effect
20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18.) Fracture of Left Shoulder 1/10/62
Fell in home, fell over some andirons
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office b'dg., etc.) 20f. (City or town) (County) (State)
Hour o.m. 1-10 62 While Not While at work ☐ at work ☒ Home Hyattsville P.G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASS STANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 1/24/62
SIGNATURE James I. Boyd, M.D.
EXAMINER'S NAME (Type) James I. Boyd, M.D.
Address (Street, c'ty, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF JAN. 27, 1962 22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM. 22d. LOCATION (City, town, or country) (State)
BALTIMORE, MD.
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md. ADDRESS
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
JAN 29 '62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00998

00990

1. PLACE OF DEATH a. COUNTY Prince Geo. b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Geo. Gen. Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Maryland b. COUNTY PG c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4511 Longfellow St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice F. Cogar		4. DATE OF DEATH 1 19 60		5. SEX F	
6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-03	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		11. BIRTHPLACE (County & State, or foreign country) Washington D C	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Frank Cauffman		14. MOTHER'S MAIDEN NAME Pearl Coulter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Marvin E Cogar Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO (b) Myocardial Infarction secondary to Conditions, if any, which gave rise to immediate cause (c) Coronary Inclusion DUE TO (c) Coronary Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH minutes					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1-14-62		20g. (County) 1-19-62		20h. (State) 1-19-62	
21. I certify that (I) (this hospital) attended the deceased from 1-14-62 , 19 62 , to 1-19-62 , that (I) (we) last saw the deceased alive on 1-19-62 , 19 62 , and that death occurred at 3:50 PM from the causes and on the date stated above.					
22a. SIGNATURE Edgren		22b. DATE SIGNED 1-19-62		22c. PHYSICIAN'S NAME (Type) Dr. Edgren	
22d. ADDRESS 4314 Gallatin St., Hyattsville, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 23, 1962		23c. NAME OF CEMETERY OR CREMATORIUM Arlington National	
23d. LOCATION (City, town or county) Arlington Va		23e. (State) Va		23f. (State) Va	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR JAN 24 '62	
25b. REGISTRAR'S SIGNATURE Wm. L. Prange		25c. DATE JAN 24 '62		25d. REGISTRAR'S SIGNATURE Wm. L. Prange	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00999			
CERTIFICATE OF DEATH			
00991			
1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4 Pine Ridge Rd., Highbridge	
3. NAME OF DECEASED (Type or print) James L. Conley		4. DATE OF DEATH January 10 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Helper		9. AGE (In years last birthday) 22 yrs.	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Issac L. Conley		14. MOTHER'S MAIDEN NAME Arbutus Shrewsbury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 377-40-4325	
17. INFORMANT Blanche L. Conley Same as #2 (Wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema			
DUE TO			
Conditions, if any, which gave rise to immediate cause (b) Massive left parieto-temporal brain hemorrhage			
DUE TO			
(c) Glioma of the brain			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Chronic Rheumatic Heart Disease with mitral stenosis and aortic stenosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/9 to 1/10 , 19 62 , that (I) (we) last saw the deceased alive on 1/10 , 19 62 , and that death occurred at 12:05 from the causes and on the date stated above.			
22a. SIGNATURE Leon L. Gallin MD		22b. DATE SIGNED P.M.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/62	
23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City, town or county) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE JAN 15 '62	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Knaus	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please call the State Health Department, Baltimore 1, Maryland, for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patrick Francis Connolly	4. DATE OF DEATH Last Middle First January 29, 1962	5. SEX Male	
6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1903	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Ireland	
13. FATHER'S NAME COLEMAN CONNOLLY		14. MOTHER'S MAIDEN NAME NORA KEANE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 210-03-3027	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (b) CORONARY ARTERY THROMBOSIS (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e); 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23. SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		24. DATE SIGNED 1/29/62	
25. ADDRESS (Street, city, town, or county) W. W. Chambers Co. Riverdale, Md.		26. LOCATION (City, town, or county) (State) Washington, D.C.	
27. REC'D BY REG STRAR FEB 5 '62		28. REGISTRAR'S SIGNATURE Arthur L. Kane	



01001

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01-193

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>		d. STREET ADDRESS <u>110 Maryland Ave N. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joanna V Cook</u>		4. DATE OF DEATH Month Day Year <u>January 18 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/1887</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Cady Roche</u>		14. MOTHER'S MAIDEN NAME <u>Mary Roche Henson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <input type="checkbox"/>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Super Pubic Cystotomy with Excision and Fulguration of Bladder Tumor and transplanta-</u> <u>tion of Left Ureter</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u> <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>THOMAS F. COLLINS</u> attended the deceased from <u>1/20/1959</u> to <u>1/18/1962</u> , that (I) <u>SAW</u> the deceased alive on <u>1/17/1962</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Thomas F. Collins</u>		22b. DATE SIGNED <u>1-18-1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u>		22d. ADDRESS <u>322- H. St. N.E. Washington 2, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Em.</u>		23d. LOCATION (City, town, or county) (State) <u>Uxbridge, Mass</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Tees</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			



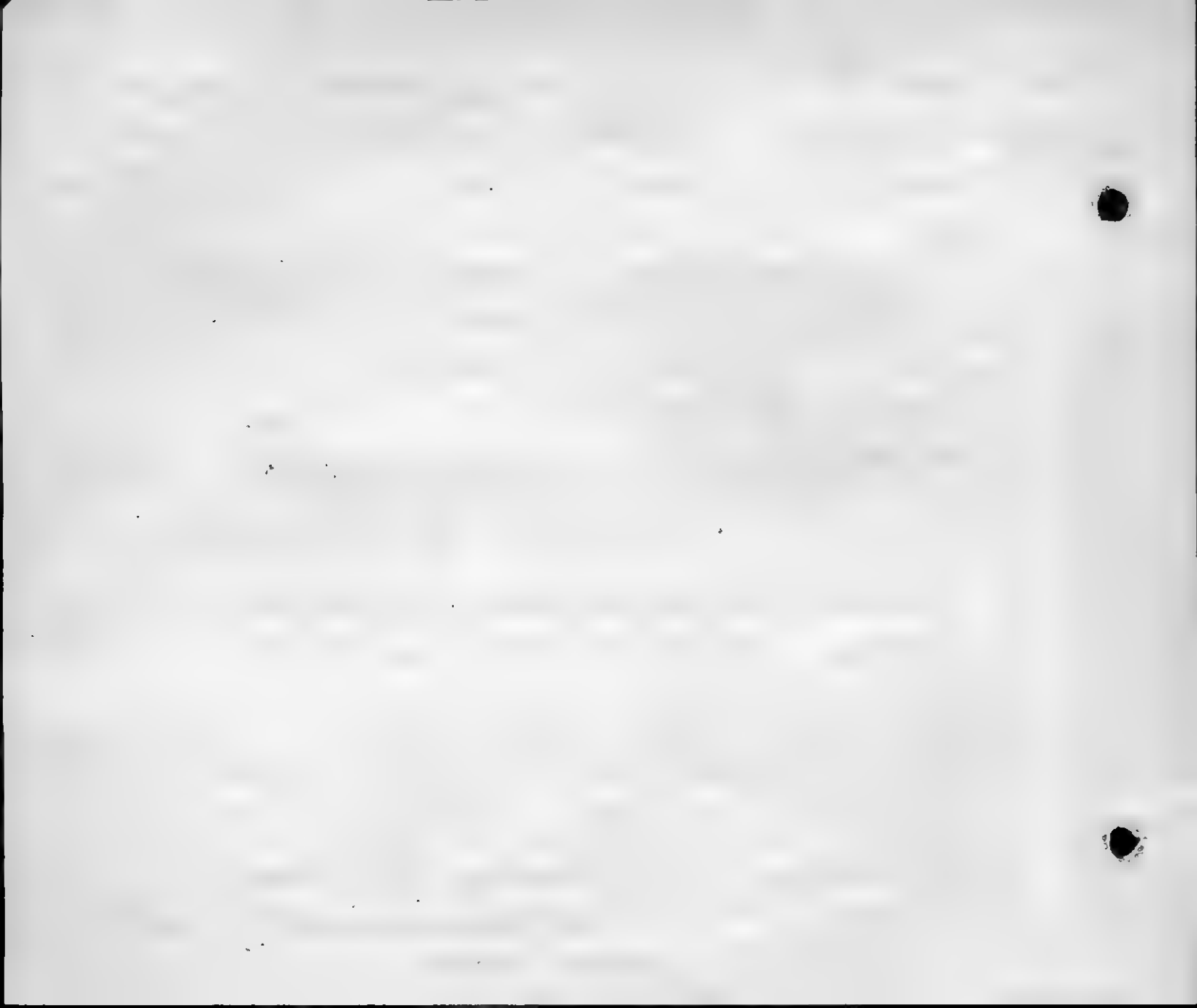
2 1
FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00094

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr - Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glassmanor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glassmanor</u>			
c. LENGTH OF STAY IN 1b <u>1 mo</u>				d. STREET ADDRESS <u>405 Kennebec</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>405 Kennebec</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Josephine Cosgrove</u>				4. DATE OF DEATH Month Day Year <u>Jan 2 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 1, 1881</u>	
9. AGE (in years less birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Barbara Porter, same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
a. I. DEATH WAS CAUSED BY: <u>4-73 X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u>							
b. DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
c. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James S. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>1-2-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-5-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>		22d. LOCATION (City, town, or country) (State) <u>28 Myers, Va</u>	
23. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>				24a. REC'D BY REGISTRAR <u>Wash, D.C.</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

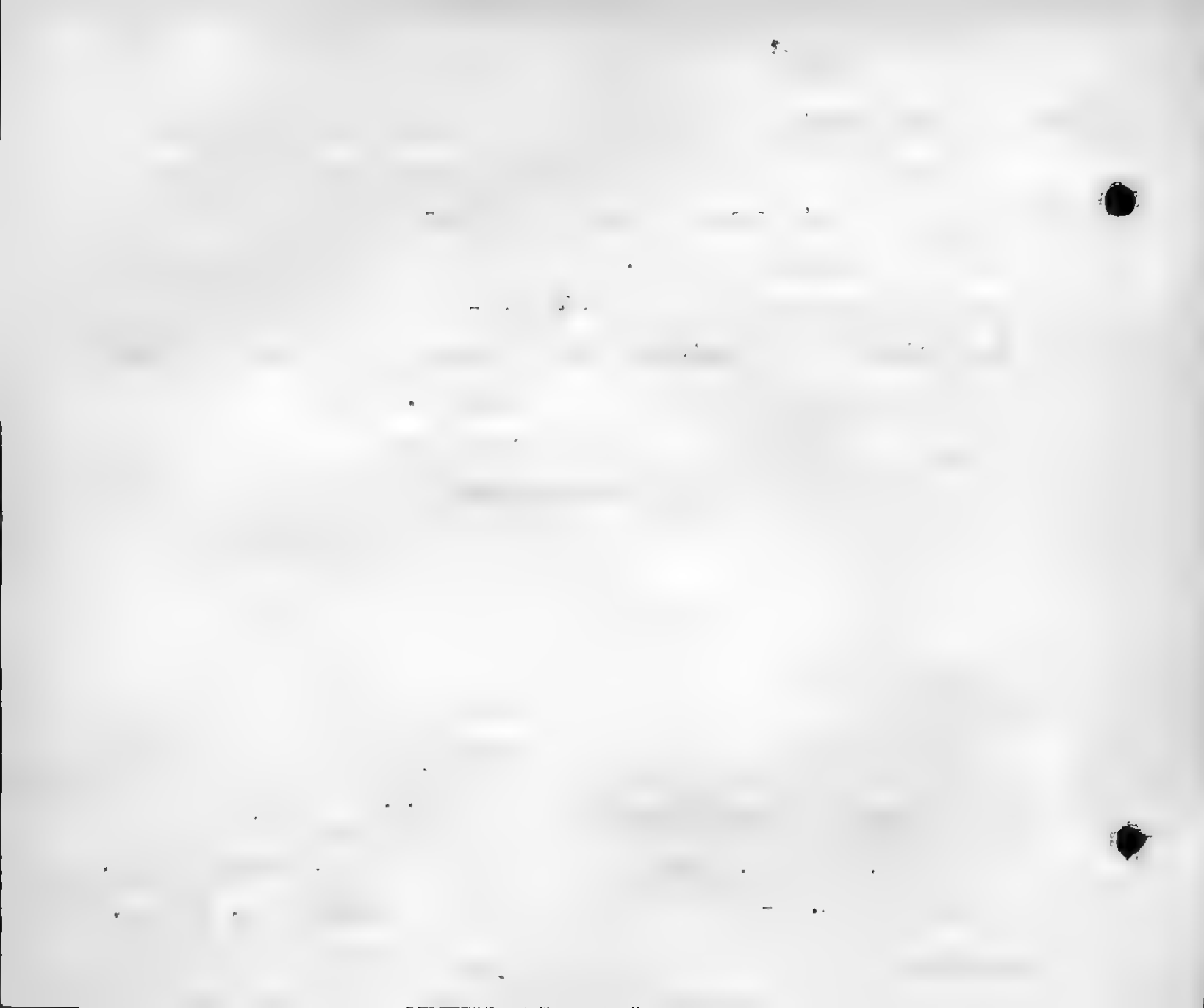
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01003

CERTIFICATE OF DEATH

00995

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights, d. STREET ADDRESS 413 - 63rd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Webster M. Courtney		4. DATE OF DEATH Month January Day 19 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-15	
9. AGE (In years last birthday) 46 yrs.		10. BIRTHPLACE (County & State, or foreign country) Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall Courtney		14. MOTHER'S MAIDEN NAME Sarah V. King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/14, 1962 to 1/19, 1962, that (I) (we) last saw the deceased alive on 1/19, 1962, and that death occurred 2:50M, from the causes and on the date stated above.			
22a. SIGNATURE <i>William B. Gunther</i> 22c. PHYSICIAN'S NAME (Type) Dr. William B. Gunther		22b. DATE SIGNED 1/19 22d. ADDRESS 9812 49th Avenue, College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22-62	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) Bladensburg, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sammons Bros.</i>		25a. REC'D BY REGISTRAR JAN 22 '62	
ADDRESS 1661 Good Hope Rd.		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kneiss</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01004

00496

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u> c. LENGTH OF STAY IN It <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>E. Leland Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> d. STREET ADDRESS <u>5704 - 36th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose</u> First Middle Last		4. DATE OF DEATH <u>Daily</u> <u>Jan</u> <u>20</u> <u>1962</u> Day Month Year		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-3-89</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>Jefferson O. Haslam</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Williamson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Rose Muller</u> <u>Daughter - 6110 - 43rd St., Hyattsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 420 <u>due to</u> <u>congestive heart failure</u> (b) <u>intermittent heart failure</u> (c) <u>and essential hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 20, 1962</u> to <u>Jan 20, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 20, 1962</u> and that death occurred at <u>7 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. W. Muller</u> M.D.		22b. DATE SIGNED <u>1-20-62</u>		22c. PHYSICIAN'S NAME (Type) <u>L. W. Muller MD</u>	
22d. ADDRESS <u>Riverdale, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 23, 1962</u>			
23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Richard D. Thomas</u>	
25c. ADDRESS <u>Riverdale Md.</u>		DATE <u>Jan 23 '62</u>			



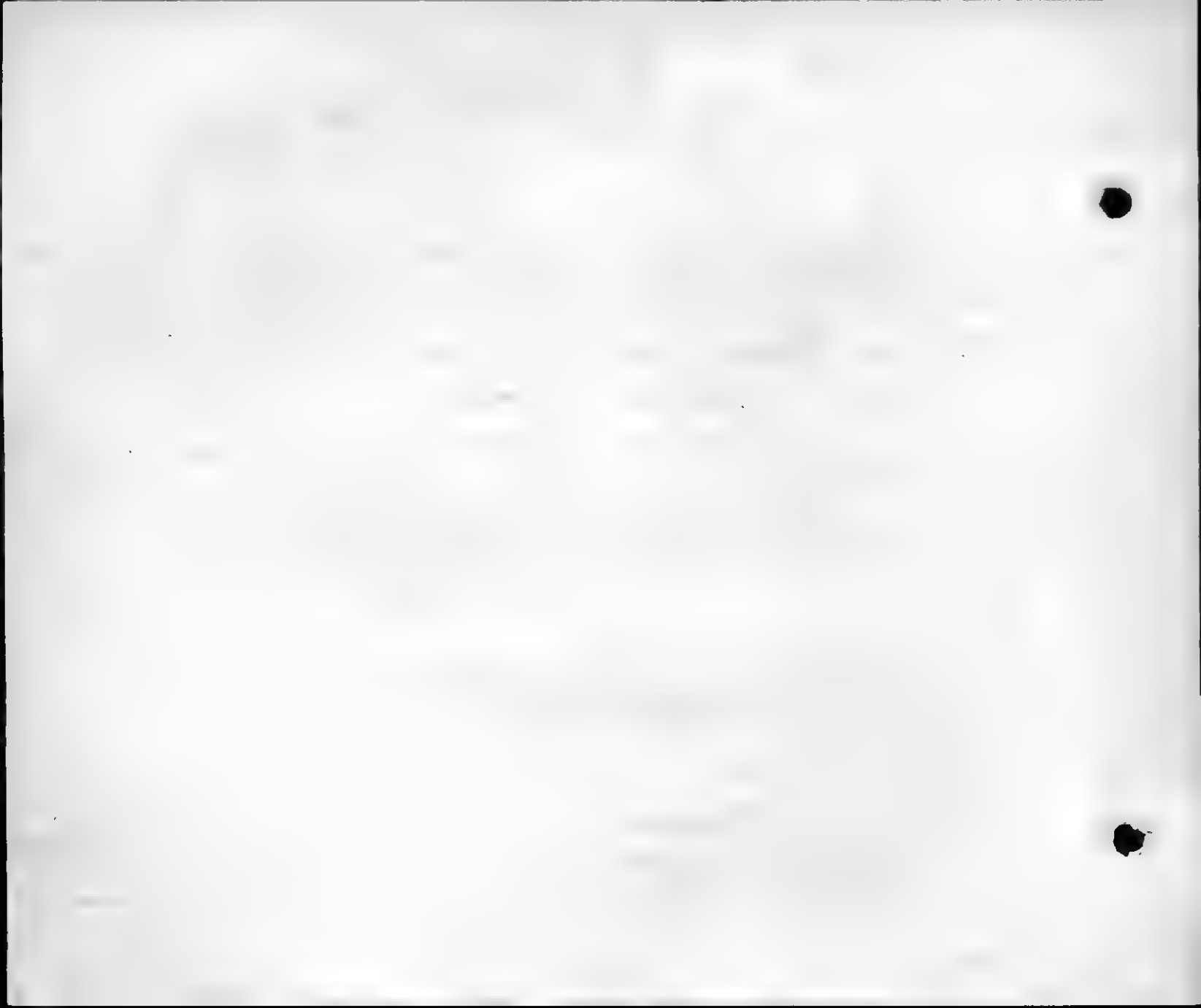
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01005

000997

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3705-Nicholson ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edwin R. DAVIS</u>				4. DATE OF DEATH Month Day Year <u>JAN 3rd 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9-1908</u>	
9. AGE (In years lost birthday) <u>53</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Laboratory Mechanic U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Davis</u>				14. MOTHER'S MAIDEN NAME <u>Lena Frye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>577-07347</u>			
17. INFORMANT <u>Bertha A. Davis</u> Address <u>3705-Nicholson ST Hyattsville Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> (c) <u>over 3yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (This hospital) attended the deceased from <u>Jan 6 1962</u> to <u>Jan 3 1962</u> , that (I) (we) last saw the deceased alive on <u>1/3/62</u> 19 <u>62</u> , and that death occurred at <u>4:45 P.</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>W. H. Clements</u>				22b. DATE SIGNED <u>JAN 3-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. CLEMENTS</u>				22d. ADDRESS <u>6001-35th Ave Hyattsville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan 6-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>				23d. LOCATION (City town or county) (State) <u>Bladensburg Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661- Good Hope Rd SE Wash DC</u>				25a. REC'D BY REGISTRAR <u>JAN 8 '62</u>			
				25b. REGISTRAR'S SIGNATURE <u>C. J. S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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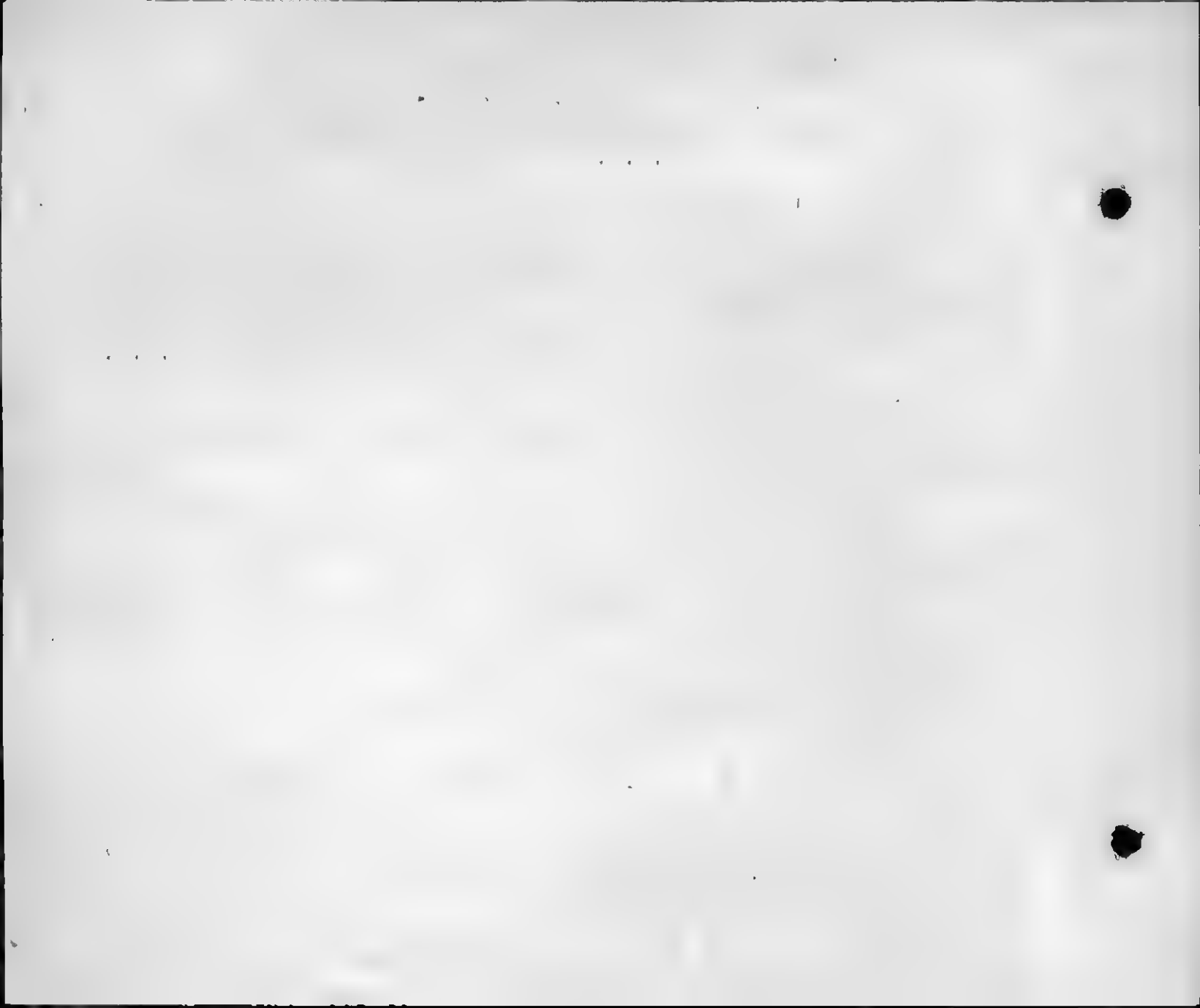
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0098

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN It D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 5419 67th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Tamara Mae Derdock			4. DATE OF DEATH January 26 19 62		
5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH November 14, 61		
9. AGE (In years last birthday) 2 yrs.			10. IF UNDER 1 YEAR 2 12 Months Days		
11. IF UNDER 24 HRS. Hours Min.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) District of Columbia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Gilbert Derdock			14. MOTHER'S MAIDEN NAME Theresa Lee		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		
17. INFORMANT James Gilbert Derdock, same as # 2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X DUE TO 493X DUE TO 493X			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED January 26, 1962					
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					
22b. DATE THEREOF 1/29/62					
22c. NAME OF CEMETERY OR CREMATORY WASH NAT					
22d. LOCATION (City, town, or country) (State) SUITHLAND MD					
23. FUNERAL DIRECTOR WW CHAMBERS CO RIVERDALE MD					
24a. REC'D BY REGISTRAR JAN 30 '62					
24b. REGISTRAR'S SIGNATURE G. S. Thomas					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01007

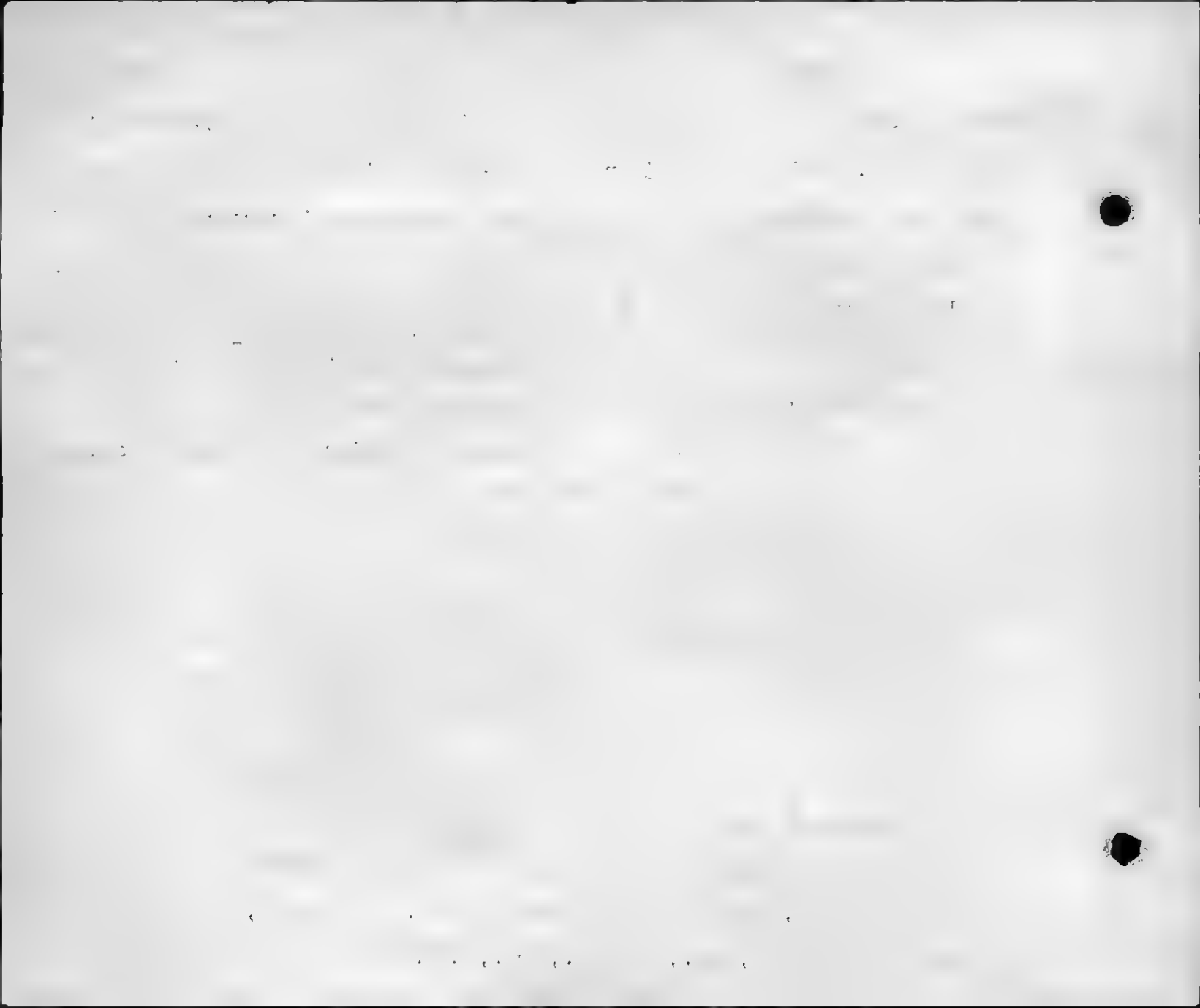
010000

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB MARYLAND c. LENGTH OF STAY IN 1b 3 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB MARYLAND d. STREET ADDRESS LOT 28 andrews trailer court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DENNIS D DILLS Male		4. DATE OF DEATH Month Day Year JAN 6 1962		5. SEX Male			
6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 June 53			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF Hospital Wright Paterson Dayton Ohio		10b. KIND OF BUSINESS OR INDUSTRY USAF Hospital Wright Paterson Dayton Ohio		9. AGE (In years last birthday) 8 yrs. 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WALTER CARL DILLS JR 11							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No							
16. SOCIAL SECURITY NO. None							
17. INFORMANT Father Lot 28 Trailer Pk Andrews AFB Wash 25 DC							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (b) General Debilitation (a), stating the underlying cause last. (c) General Debilitation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) Tay Sachs Disease 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (in this hospital) the deceased was observed only after 12 hours (if we) last saw the deceased alive on 19....., and that death occurred at.....M, from the causes and on the date stated above 21a. SIGNATURE Heathley S. Stepp 21b. DATE SIGNED 22a. PHYSICIAN'S NAME (Type) STEPP Heathley D 22b. DATE SIGNED 22c. ADDRESS USAF Hosp ANDREWS ANDREWS AFB MD 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9 Jan, 1962 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. 23d. LOCATION (City, town or county) (State) Arlington, Virginia 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rinaldi Funeral Home, Inc., 7400 Ga., Ave., N.W. 25a. REC'D BY REGISTRAR JAN 11 '62 25b. REGISTRAR'S SIGNATURE William S. Kram							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

WASH., DC.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01008
CERTIFICATE OF DEATH
01000

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 39 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 44 B Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George First Middle Edmund Last Diven		4. DATE OF DEATH January 22 Month Day Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1888 9. AGE (in years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY general store	
11. PLACE (County & State, or foreign country) Laurel Maryland U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Diven		14. MOTHER'S MAIDEN NAME Dora Ellen Snapper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-105485A	
17. INFORMANT Mrs Margaret Lewis Laurel Md.		Address 44 B Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Acute Pulmonary Edema. Arteriosclerotic Heart Diseases		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/14 to 1/22, 1962, that (I) (we) last saw the deceased alive on 1/22, 1962, and that death occurred at 2:45 M, from the causes and on the date stated above.			
22a. SIGNATURE R.D. Baner		22b. DATE SIGNED 1-22-62	
22c. PHYSICIAN'S NAME (Type) R.D. Baner M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Prince Georges Hospital Cheverly Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial Jan. 24, 1962		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Inglis Hill Cemetery		23d. LOCATION (City, town or county) Laurel Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE L.E. With Donaldson		25a. REC'D BY REGISTRAR DATE JAN 29 '62	
25b. REGISTRAR'S SIGNATURE O'Donnell & Flanagan			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01009

01001

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>4 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rockville Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47 Mt Rainier</u> d. STREET ADDRESS <u>14503 2nd St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Rose</u> <u>Middle</u> <u>Isabel</u> <u>Last</u> <u>Dixon</u>		4. DATE OF DEATH Year <u>1962</u> Month <u>Jan</u> Day <u>31</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-1956</u>		9. AGE (In years) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired waitress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Med school</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George F. Zite</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Bell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <u>Hospital Record</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <input type="checkbox"/> DUE TO (c) <input type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1/31</u> to <u>1/31</u> 1962 ; that (I) (we) last saw the deceased alive on <u>1/31</u> 1962 ; and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Earl W. Graeff</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-31-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u>				22d. ADDRESS <u>2716 Kirkwood Pl. W. Hyattsville, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. E. Smith's sons Hyattsville Md</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

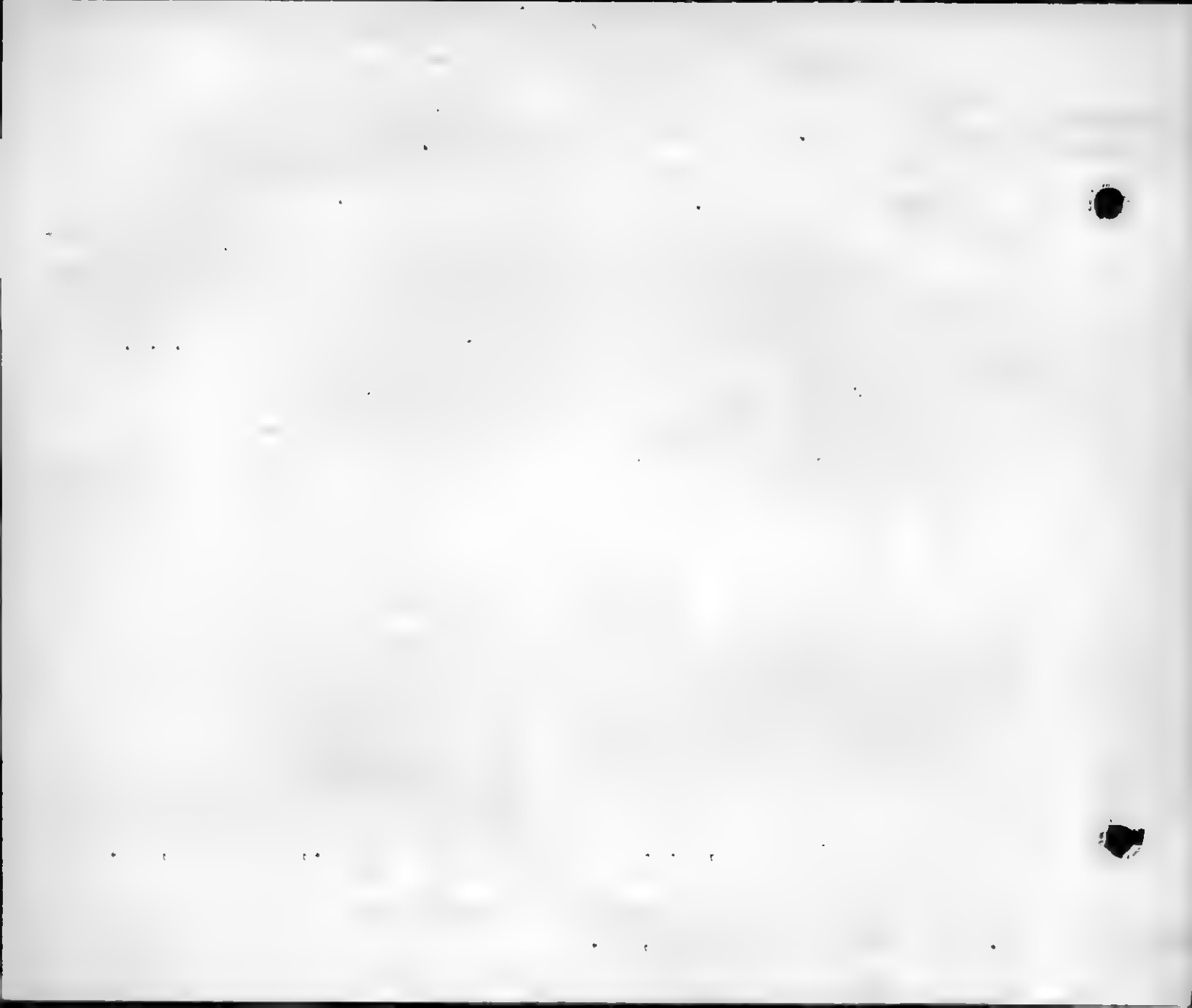
CERTIFICATE OF DEATH

01010

Items 5 & 6 Film G305 1/11/62 iwk

01002

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERWYN HEIGHTS		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERWYN HEIGHTS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR HOME 8502 60th AVE.		d. STREET ADDRESS 8502 60th AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle DRUMMOND Last DRUMMOND		4. DATE OF DEATH Month JAN. Day 4 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 19, 1878
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME OWNER	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME REVEL LEWIS		14. MOTHER'S MAIDEN NAME VIRGINA ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT ROCKWELL DRUMMOND		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Pyelonephritis and cystitis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost urologic venereal infection (b) urologic venereal infection (c) urologic venereal infection		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) brother's pneumonia large abscess		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 29th 1961 to Jan 4th 1962 , that (I) (we) last saw the deceased alive on Jan 3rd 1962 , and that death occurred at 1:40 P.M. from the causes and on the date stated above			
22a. SIGNATURE Till Bergemann, M.D.		22b. DATE SIGNED 1/4/62	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M.D.		22d. ADDRESS 53 A Crescent Rd., Greenbelt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 6, 1962	
23c. NAME OF CEMETERY OR CREMATORY Drummond Cemetery		23d. LOCATION (City, town, or county) (State) Sanford Va.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR JAN 8 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

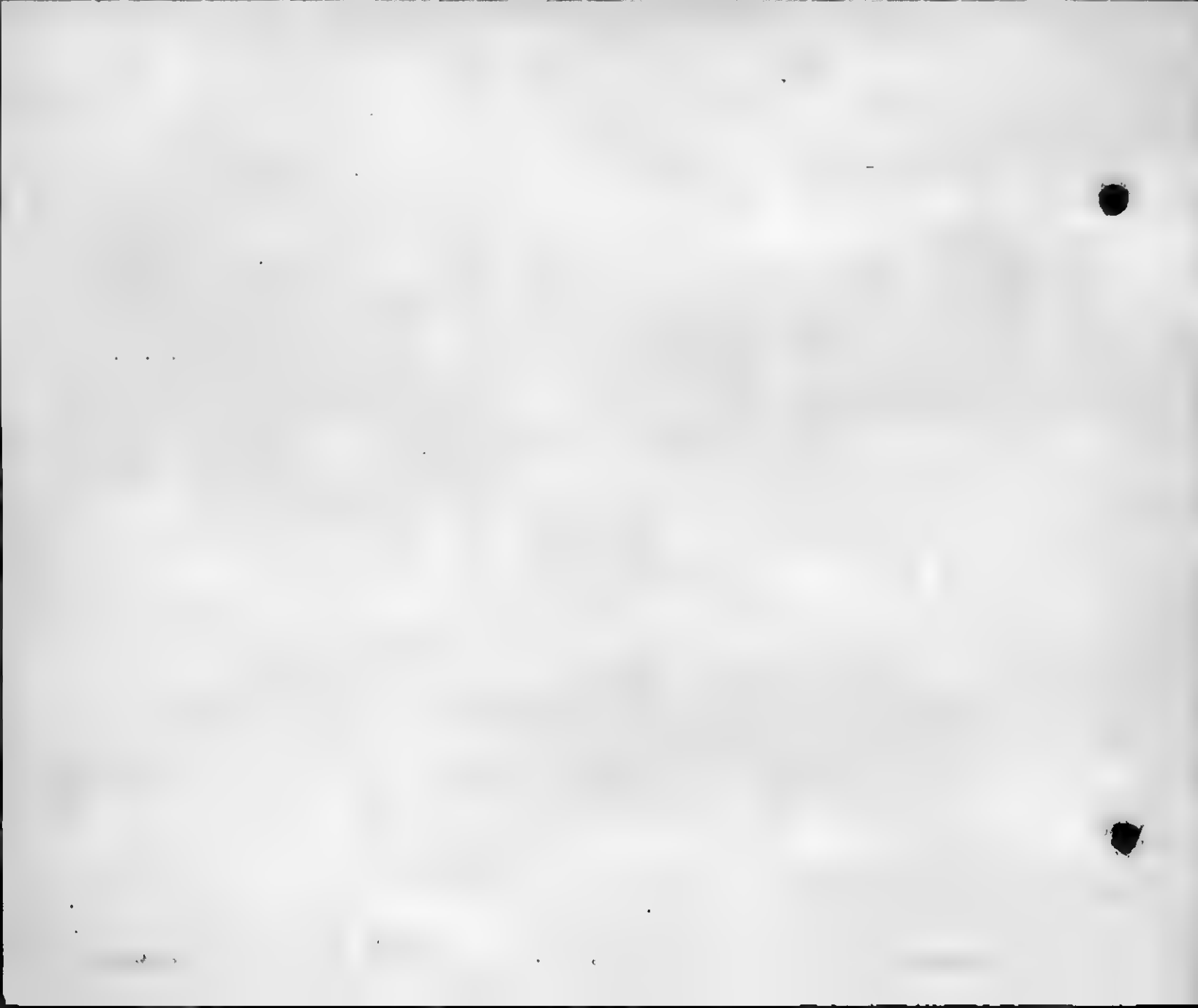
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01011

01003

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highbridge-Bowie c. LENGTH OF STAY IN b 8 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Highbridge Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highbridge Bowie d. STREET ADDRESS Highbridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie M. Eaton Female White Housewife		4. DATE OF DEATH Jan. 12, 1962 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 30, 1902 9. AGE (In years, rest birthday) 59 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lawrence Africa		14. MOTHER'S MAIDEN NAME Elsie Brantner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles W. Eaton Same as #2 (Husband)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension & Obesity	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 2/4 1962 to 1/12 1962, that (I) (we) last saw the deceased alive on 12/2 1961, and that death occurred at 1/12 1962, from the causes and on the date stated above. 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 22e. DATE SIGNED 22f. DATE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/62	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR JAN 17 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01012

01004

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN TB <u>2 yrs 9 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home Inc.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3400 - 13th St, S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ALICE</u> F. M. Middle 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>1/25/1962</u> Last Month Day Year 8. DATE OF BIRTH <u>10/15/03</u> Last Month Day Year 9. AGE (In years last birthday) <u>58</u> yrs. Months Days Hours Min. 11. BIRTHPLACE (Country & State, or foreign country) <u>St. Marys Co. Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 13. FATHER'S NAME <u>John R. Harden</u> 14. MOTHER'S MAIDEN NAME <u>Sane Rebecca Thompson (Harden)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Wm. J. Eckstern, 3400 - 13th St, S.E., Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO (b) <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/62</u> to <u>1/25/62</u> , that (I) (we) last saw the deceased alive on <u>1/24/62</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Robert A. Mattingly</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Mattingly</u> 22d. ADDRESS <u>131 - 11th St, Wash. D.C.</u> 22e. REC'D BY REGISTRAR <u>Jan 29 '62</u> 22f. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-29-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Redan Hill</u> 23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> 25b. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

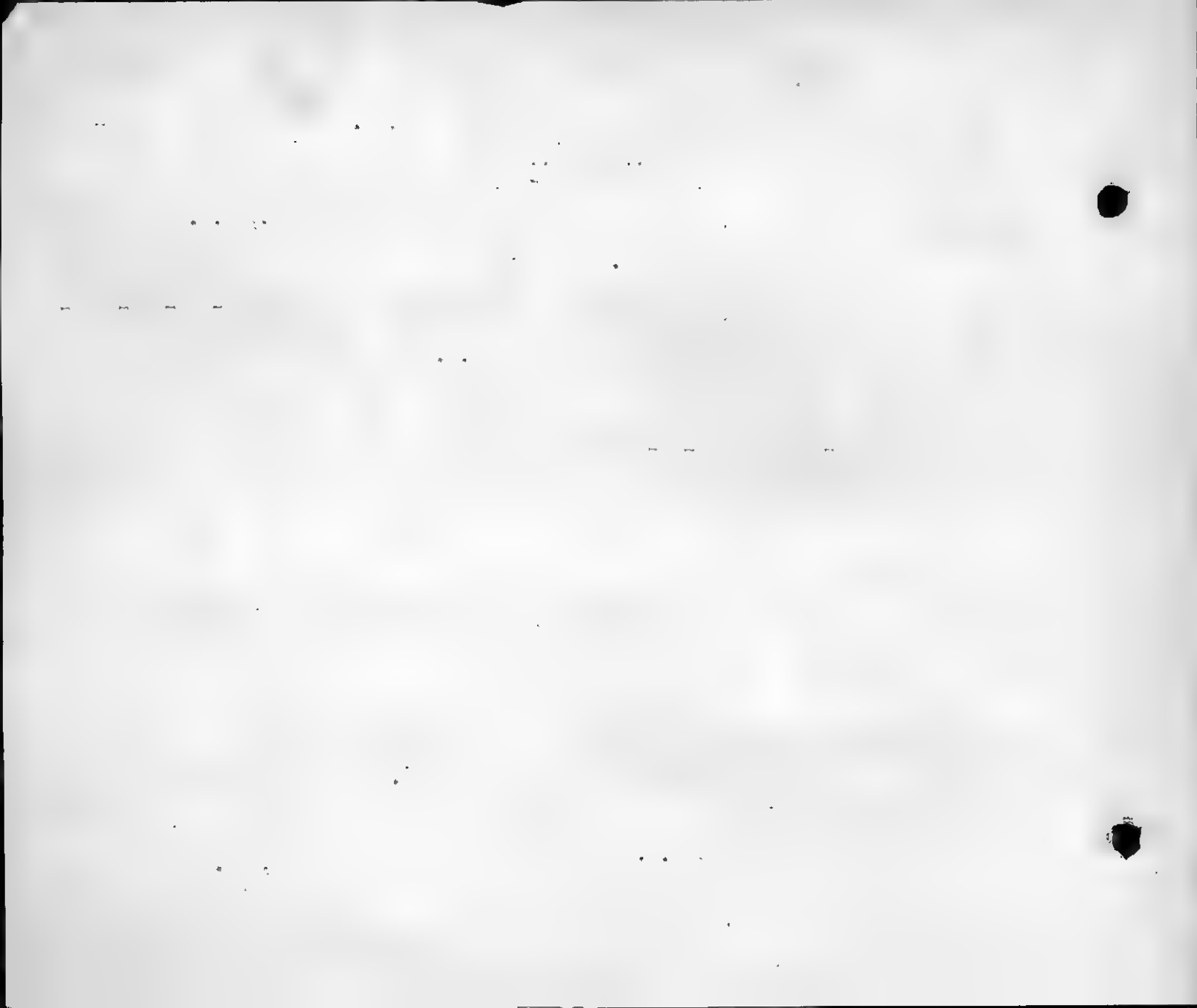
CERTIFICATE OF DEATH

01013

Items 23 Film G506 2/5/62 ink

01005

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr., 3 mos., & 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 3109 35th St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Willie J. Evans		4. DATE OF DEATH 1 28 19 62		5. SEX Male	
6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -		9. AGE (In years last birthday) 81 yrs.	
11. BIRTHPLACE (County & State, or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andrew Evans	
14. MOTHER'S MAIDEN NAME Frances ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 250-32-2814	
17. INFORMANT Decedent		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 7 yr. 7 mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Right pneumonitis; chronic pancreatitis; chronic pyelonephritis, mild		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)		20c. TIME OF INJURY Month, Day, Year 10/5/1960	
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1/28/1962	
20g. (County)		20h. (State)		21. I certify that (I) (this hospital) attended the deceased from 10/5/1960 to 1/28/1962, that (I) (we) last saw the deceased alive on 1/28/1962, and that death occurred at P.M. from the causes and on the date stated above.	
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 1/28/62		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 2/3/1962		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	
23d. LOCATION (City, town or county) Park, Maryland		23e. (State)		24. FUNERAL DIRECTOR'S SIGNATURE	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE FEB 1 '62	



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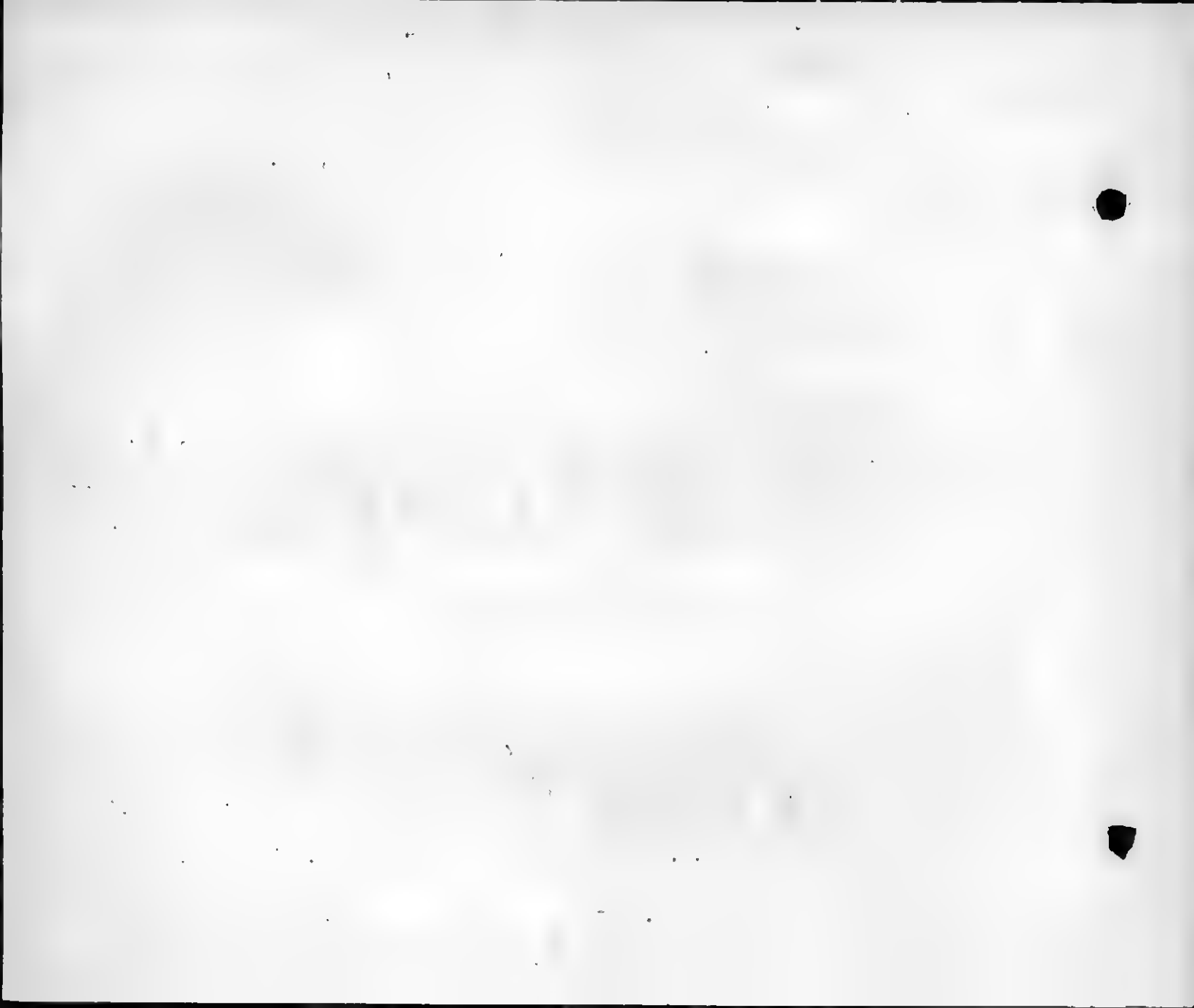
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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01014

01006

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5702 Eastpines Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Genevieve Farrell		4. DATE OF DEATH Month Jan Day 19 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17, 1876
9. AGE (In years lost birthday) 85 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Thall		14. MOTHER'S MAIDEN NAME Anna Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Lambert Fritsch		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 12200 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic heart disease DUE TO 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1962 to Jan 19, 1962 that (I) (we) last saw the deceased alive on 18 Jan 1962 and that death occurred at 8:00 PM from the causes and on the date stated above			
22a. SIGNATURE John Kehoe		22b. DATE January 19, '62	
22c. PHYSICIAN'S NAME (Type) John Kehoe M.D.		22d. ADDRESS 6300 Riverdale Rd. Riverdale, Maryland	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/62	
23c. NAME OF CEMETERY OR CREMATORY St. Basil's		23d. LOCATION (City, town, or county) (State) Dinkers Pa	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Pascho Sons		25a. REC'D BY REGISTRAR DATE JAN 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20c Film 305
1-22-62
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01007

1. PLACE OF DEATH
a. COUNTY Prince Georges County MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 8 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville
d. STREET ADDRESS 11629 35th Avenue

3. NAME OF DECEASED (Type or print) ANNA (NMN) FERCHAK
First Middle Last
4. DATE OF DEATH January 14, 1962
Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH Nov. 17, 1892
WIDOWED ☒ DIVORCED ☐ 9. AGE (in years last birthday) 69
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (State or foreign country) Austria 12. CITIZEN OF WHAT COUNTRY U.S.A.

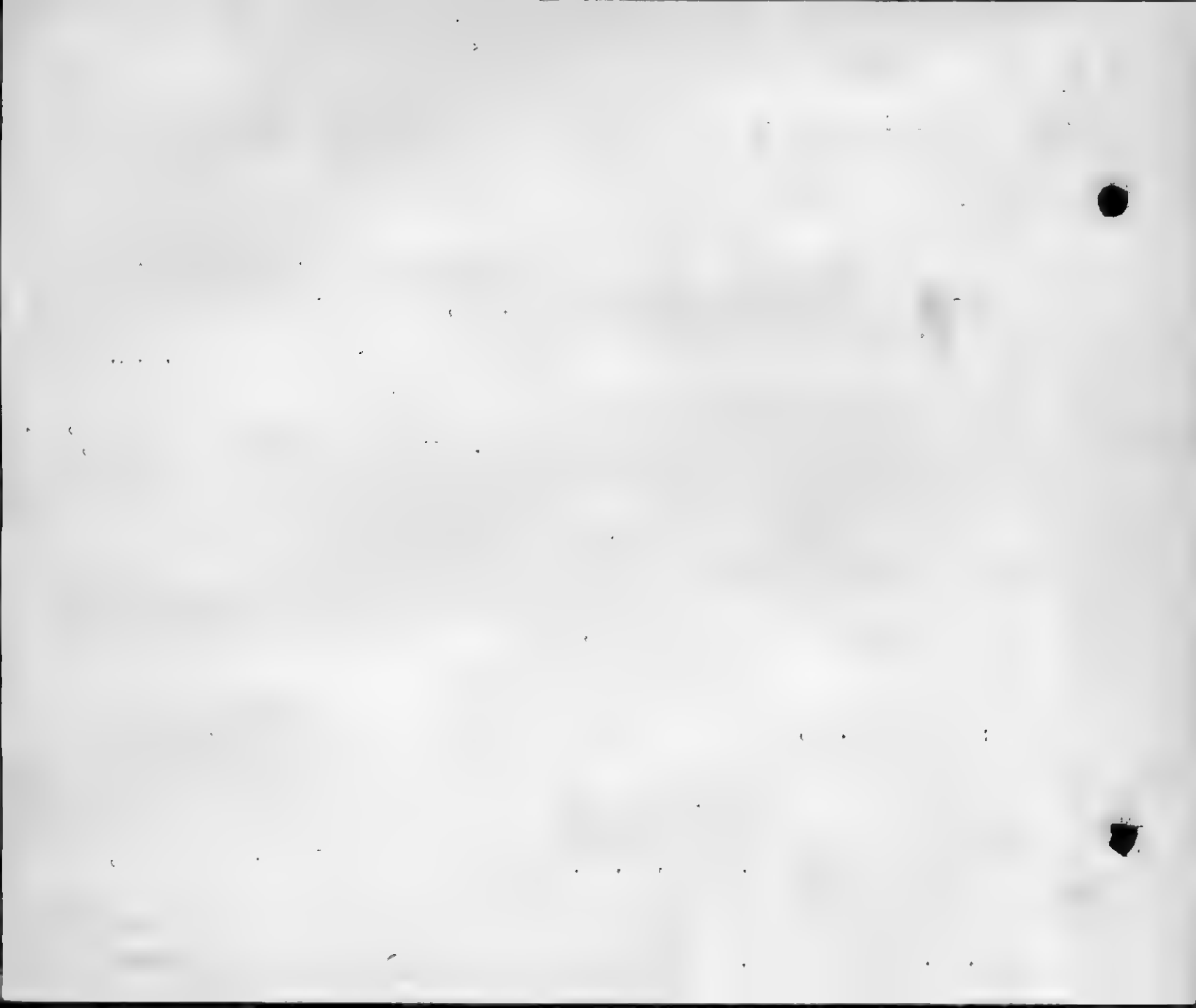
13. FATHER'S NAME Carl Novotny 14. MOTHER'S MAIDEN NAME Anna Fumichael
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT John J. Ferchak, 11629 35th Avenue, Beltsville, Md.
Address

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
142X DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease
(c) DUE TO
(e), stating the underlying cause last.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left hip, Carcinoma of the stomach
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in Bathroom of Home
20c. TIME OF INJURY Month, Day, Year 5 Jan. 16, 1962 20d. INJURY OCCURRED While ☐ Not While ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home 20f. (City or town) Beltsville, Maryland (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D. EXAMINER'S NAME (Type) JAMES I. BOYD, M. D. DATE SIGNED January 15, 1962
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 22b. DATE THEREOF JAN 18, 1962 22c. NAME OF CEMETERY OR CREMATORY ST. NICHOLAS GREEK CATHOLIC 22d. LOCATION (City, town, or country) BROWNSVILLE, PENN'A.
23. FUNERAL DIRECTOR W. W. CHAMBERS CO. ADDRESS Riverdale, Maryland 24a. RECORD BY REGISTRAR JAN 17 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Huns



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STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

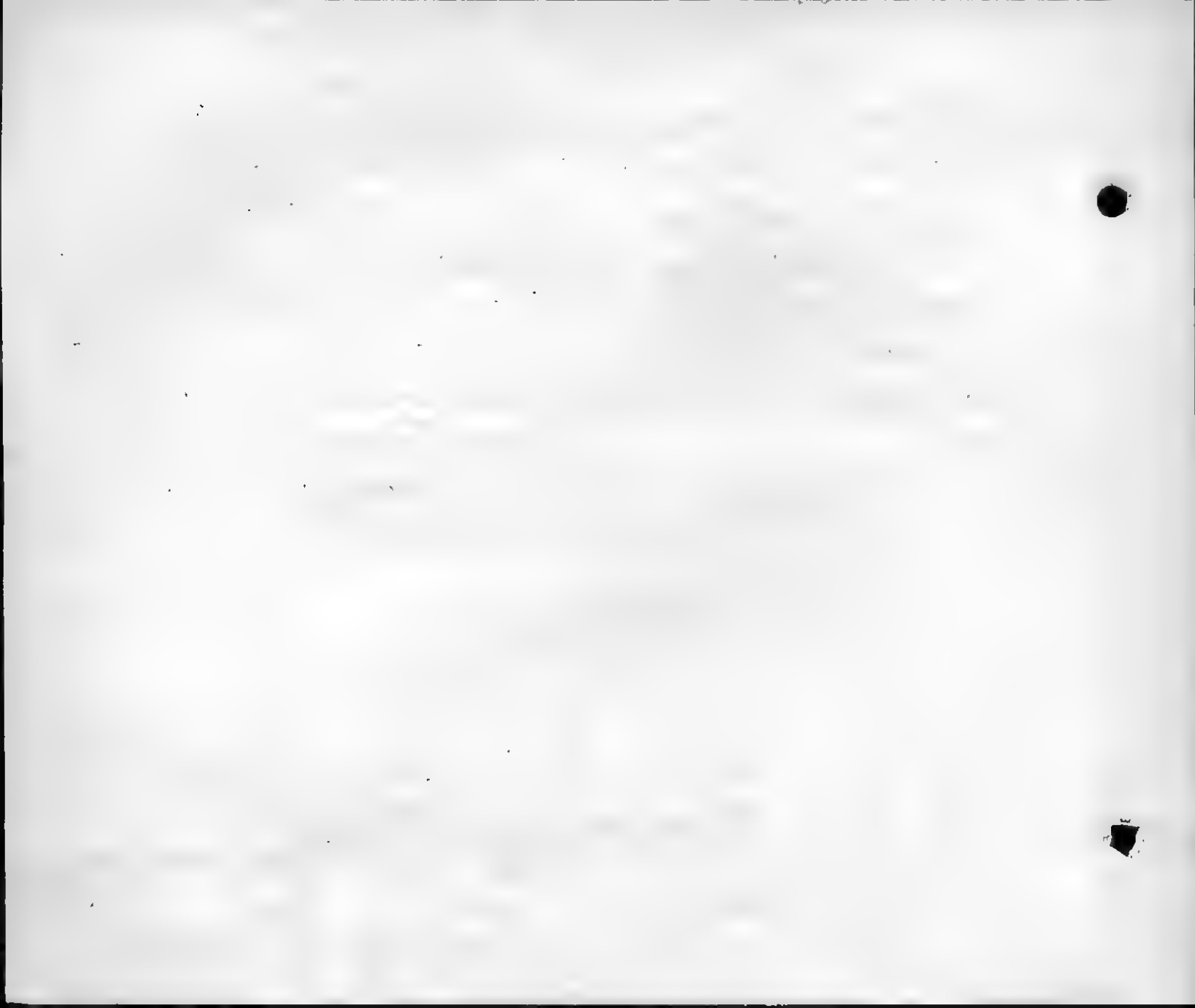
01016

01008

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before, admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HEIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 CAPITOL HEIGHTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>608-51st Ave.</u>		d. STREET ADDRESS <u>608-51st Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>FITZGERALD</u>		4. DATE OF DEATH Month <u>1-</u> Day <u>25-</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 11, 1889</u>
9. AGE (In years lost birthday) <u>72</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>WASH D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHRISTIAN YOUNG</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>EDWARD FITZGERALD</u>	
17. INFORMANT <u>EDWARD FITZGERALD</u>		Address <u>2 D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>44 X Anteromedullary Basilar Artery</u> DUE TO (b) <u>Renal. Disease</u> DUE TO (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> 19 <u>61</u> to <u>1/25</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/25</u> 19 <u>62</u> , and that death occurred at <u>7:20</u> A.M. from the causes and on the date stated above			
22a. SIGNATURE <u>William Brainin</u> M.D.		22b. DATE SIGNED <u>1/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		22d. ADDRESS <u>6124 Central Ave, Capitol Heights Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/29/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Unm... H... - 4748</u>		25a. REC'D BY REGISTRAR <u>Jan 31 '62</u>	
ADDRESS <u>Unm... H... - 4748</u>		25b. REGISTRAR'S SIGNATURE <u>...</u>	

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01017

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01069

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW JERSEY b. COUNTY ATLANTIC			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 2 YRS-3MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle GRANT Last FOULOIS				4. DATE OF DEATH JAN. 15 1962 Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 DECEMBER 1882	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME WILLIAM GRANT				14. MOTHER'S MAIDEN NAME HARRIET SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT BENJAMIN D FOULOIS Address SHELTON MANOR ANDREWS AFBASE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, L.F. LOWER LOBE DUE TO (b) Atherosclerotic heart disease DUE TO (c) and calcific aortic valvulitis INTERVAL BETWEEN ONSET AND DEATH 9 days 27 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1 Oct. 1959 to 15 Jan. 1962 that (I) (me) last saw the deceased alive on 15 Jan. 1962 and that death occurred 11:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Paul Bittick Jr 4 Col USAF (MC)				22b. DATE SIGNED 15 JAN 62			
22c. PHYSICIAN'S NAME (Type) PAUL BITTICK JR, LCOL USAF MC				22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		1-18-62		West Laurel Hill Cemetery		Bala-Cynwyd Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE WW Chambers Co ADDRESS Wash DC 517-1125 ST SE				25a. RECEIVED BY REGISTRAR JAN 17 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Kneiss	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the office of the Director, in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you or filed. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

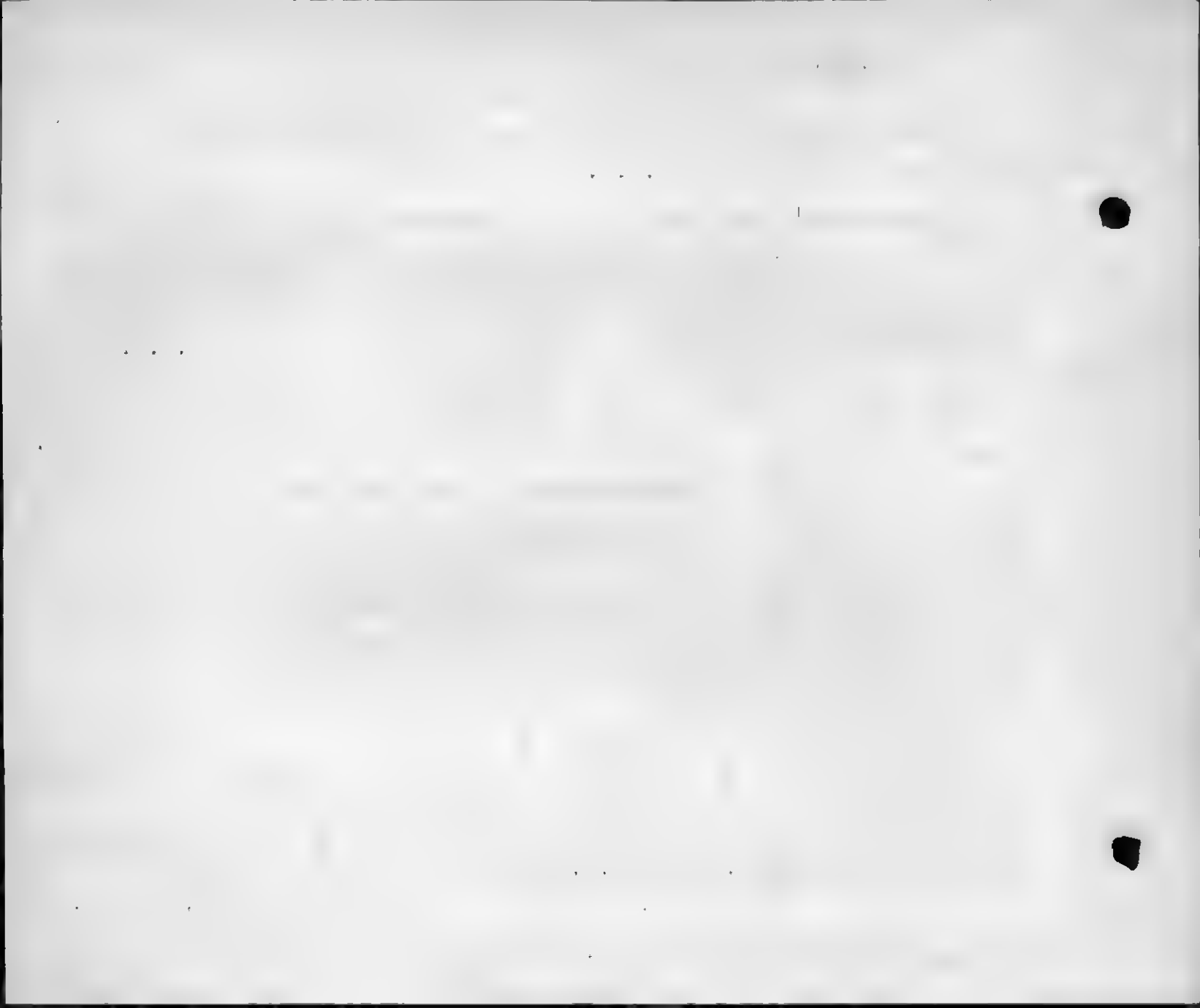
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01010

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4504 Emerson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurine Selig Fowler		4. DATE OF DEATH January 24th, 1962		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/1897	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simon William Selig		14. MOTHER'S MAIDEN NAME Esther Menke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Bertha Fowler Mackey Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1-20-1 Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetic for 20 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/62		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
22d. LOCATION (City, town, or country) Colmar Manor, Md.		22e. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22f. LOCATION (City, town, or country) Colmar Manor, Md.	
23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JAN 26 '62	
24b. REGISTRAR'S SIGNATURE James I. Boyd		DATE SIGNED 1/24/62		24c. REGISTRAR'S SIGNATURE James I. Boyd	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9'60

MARYLAND STATE DEPARTMENT OF HEALTH

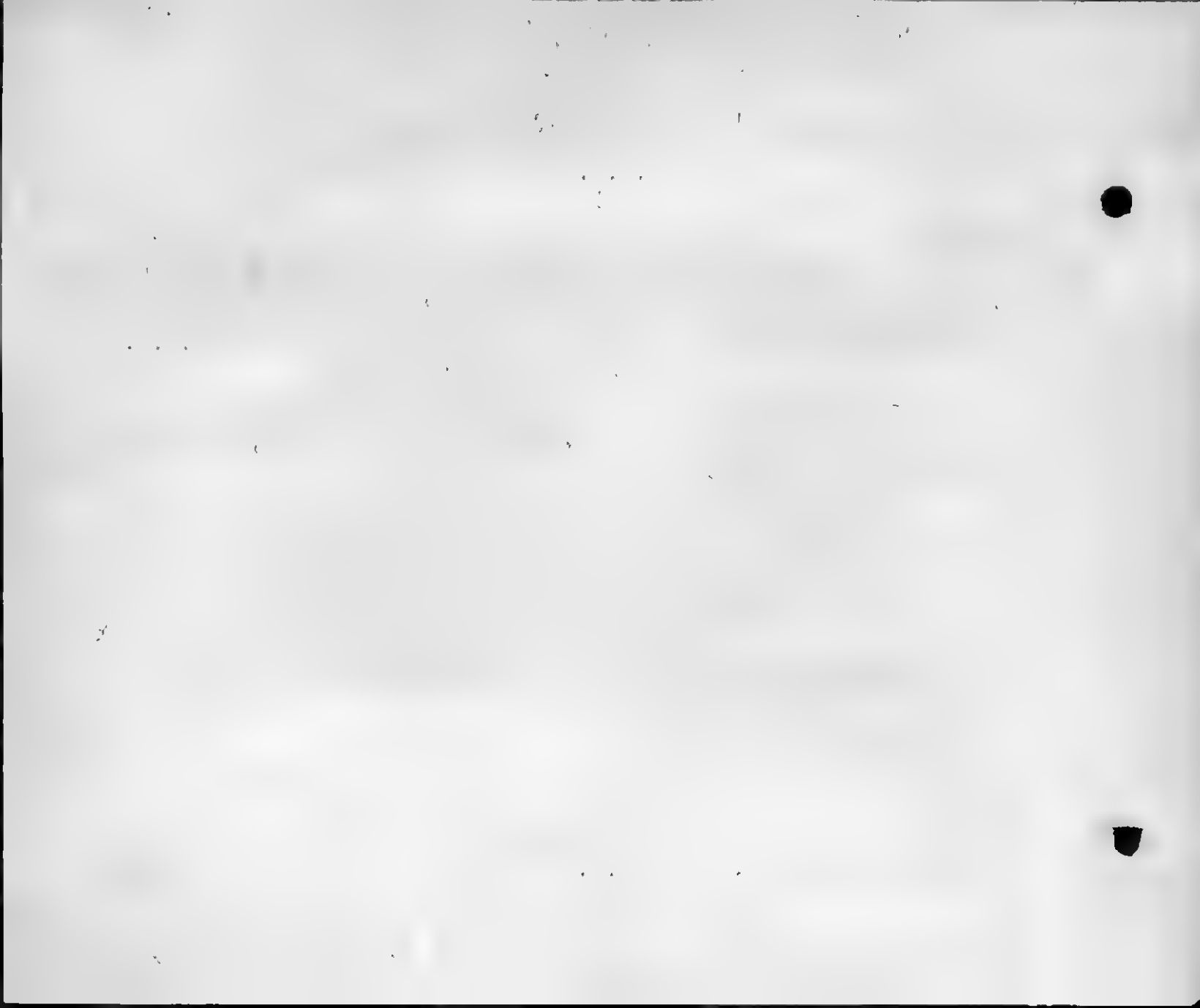
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01019 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01011

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>63 Rogers Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				e. STREET ADDRESS <u>5006 Edmonston Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Hilda Elizabeth Fretwell</u>				4. DATE OF DEATH <u>January 12, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1907</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>Harry Cissel</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Johnson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Ernest Homer Fretwell, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>416X</u> IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO (b) <u>RHEUMATIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month. Day. Year <u> </u> 19 <u> </u> <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>1/13/62</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u> </u>				22a. REC'D BY REG STRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>			
22b. DATE THEREOF <u>1-16-1962</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Em</u>			
22d. LOCATION (City, town, or county) (State) <u>Blacksburg, Maryland</u>				23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Pimlico, Md.</u>			

MEDICAL CERTIFICATION



3 14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please inform the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01012

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b D.O.A.			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 3912 Queensberry Road		
3. NAME OF DECEASED (Type or print) First Middle Last James Howard Galentine			4. DATE OF DEATH Month Year January 20, 19 62		
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 12, 1913 9. AGE (in years last birthday) 48 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent Building			10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		
13. FATHER'S NAME Homer Pletcher Galentine			14. MOTHER'S MAIDEN NAME Catherine Henry		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 578-10-1280 17. INFORMANT Address Leona Catherine Galentine, same as # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 41 Acute congestive heart failure Rheumatic heart disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month. Day Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 21, 19 62		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/24/62			22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln 22d. LOCATION (City, town, or country) (State) Bladensburg, Md.		
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.			24a. REC'D BY REGISTRAR DATE JAN 25 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna		



may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01021

01013

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>Hudson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hudson</u>			
c. LENGTH OF STAY IN 1b <u>mths</u>				d. STREET ADDRESS <u>210 North Church St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>409 Elm Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NINA</u> Middle <u>BELLE</u> Last <u>GALLOWAY</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 9, 1880</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bryan, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Migord Rosa</u>				14. MOTHER'S MAIDEN NAME <u>Juliette Beach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mrs. Russell B. Jones, (same as #1.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>							
DUE TO (b) <u>Senile Arteriosclerosis Generalized</u>							
DUE TO (c) <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive Diverticulitis of Sigmoid colon</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1 Nov</u> 19 <u>61</u> to <u>31 Jan</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>26 Jan</u> 19 <u>62</u> and that death occurred on <u>31 Jan</u> 19 <u>62</u> from the causes and on the date stated above							
22a. SIGNATURE <u>H.B. Queen</u> M.D.				22b. DATE SIGNED <u>31 Jan 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. B. QUEEN M.D.</u>				22d. ADDRESS <u>7112 Willow Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hudson, Michigan</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St. NW D.C.</u>				25a. REC'D BY REGISTRAR <u>FEB 2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>L. S. Plummer</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

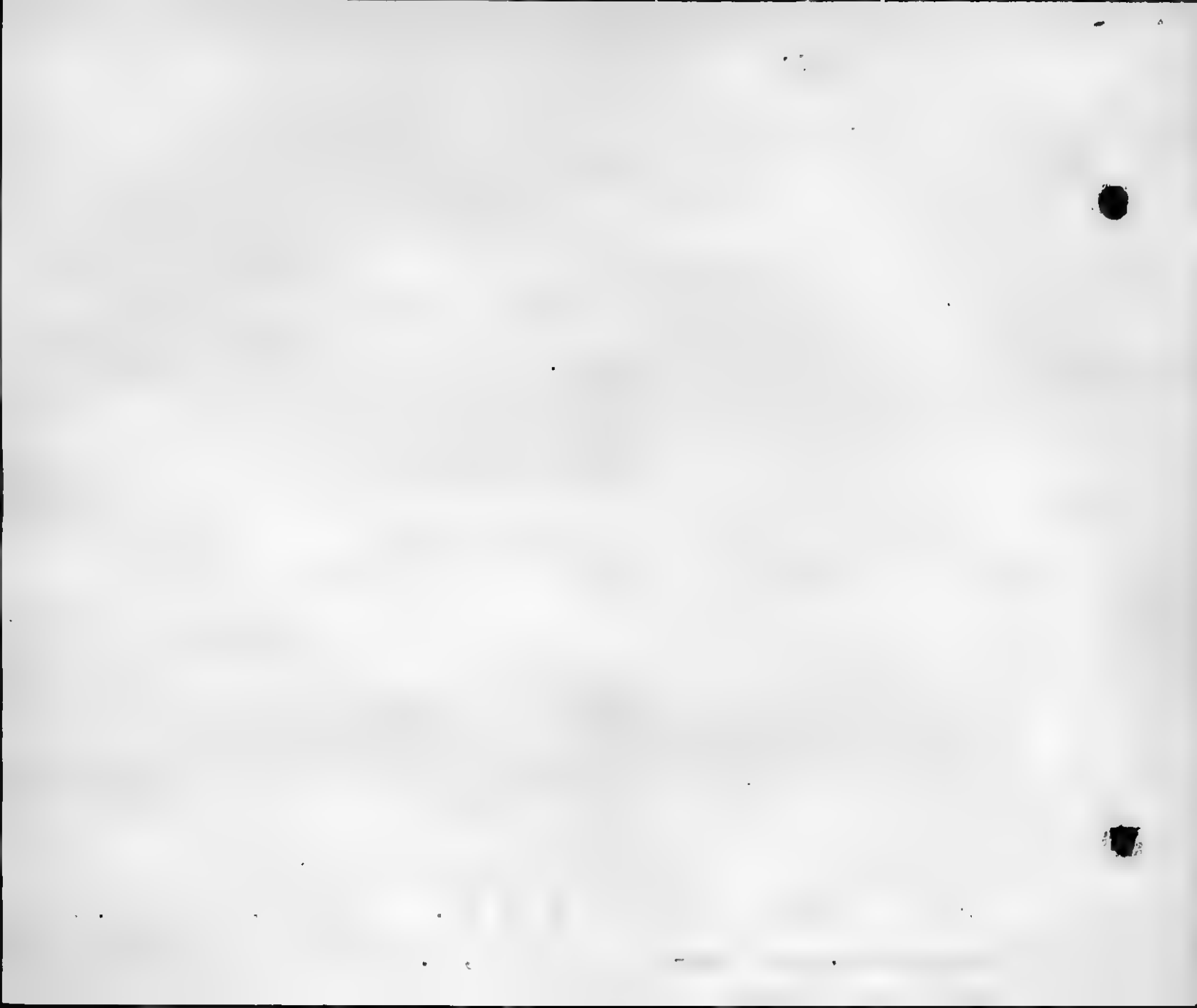
01022

CERTIFICATE OF DEATH

01011

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> c. LENGTH OF STAY IN b. <u>20 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT 1 Box 245</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CLINTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> d. STREET ADDRESS <u>RT 1 Box 245</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOUIS KRYDER</u> First Last Middle				4. DATE OF DEATH <u>JAN. 25</u> 19 <u>62</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER'S AIDE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POTTSTOWN, PA.</u>			
13. FATHER'S NAME <u>HOWARD GEIST</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WOLF</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>577-09-3322</u>			
17. INFORMANT <u>GRACE GEIST</u> Address <u>RT 1 Box 245</u> <u>CLINTON, MD.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHOPNEUMONIA</u> (b) <u>TRANSITIONAL CELL CARCINOMA OF BLADDER 3 YRS.</u> (c) <u>WITH GENERALIZED METASTASES</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH ANGINA PECTORIS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>							
20c. TIME OF INJURY <u>NONE</u> Hour a.m. p.m.		20d. INJURY OCCURRED <u>NONE</u> While at work Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>SEP. 1, 1956</u> to <u>PRES. 1962</u> , that (I) (we) last saw the deceased alive on <u>JAN. 25, 1962</u> and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				22b. DATE SIGNED <u>1/25/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. MD.</u>				22d. ADDRESS <u>FRANK AVE. - CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/27/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home</u>		24b. ADDRESS <u>Upper Marlboro, Md.</u>		25a. REC'D BY REGISTRAR <u>2852</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur Shaver</u>		25c. LOCATION (City, town or county) <u>Needmore, Penna.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>42 Cheverly</u> d. STREET ADDRESS <u>6312 Inwood Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret A Gibbons</u> First Middle Last		4. DATE OF DEATH <u>Jan 28 1962</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 March 1878</u> Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's Co. Md.</u>	
13. FATHER'S NAME <u>John Lacey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> (b) <u>Altherosclerosis</u> (c) <u>Intestinal obstruction from duodenal ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>10 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1952, 1962 to Jan 28, 1962 that (I) (we) last saw the deceased alive on Jan 26, 1962 and that death occurred at 12:01 AM from the causes and on the date stated above.	
22a. SIGNATURE <u>John Kehoe</u>		22b. DATE SIGNED <u>Jan 30 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John Kehoe, M.D.</u>		22d. ADDRESS <u>6300 RIVERDALE RD, RIVERDALE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 31st 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel B. Ross</u>		25a. REC'D BY REGISTRAR <u>Jan 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>1461-9d Hape Rd & E</u>	

8

12
FOR STATE
HEALTH DEPT.

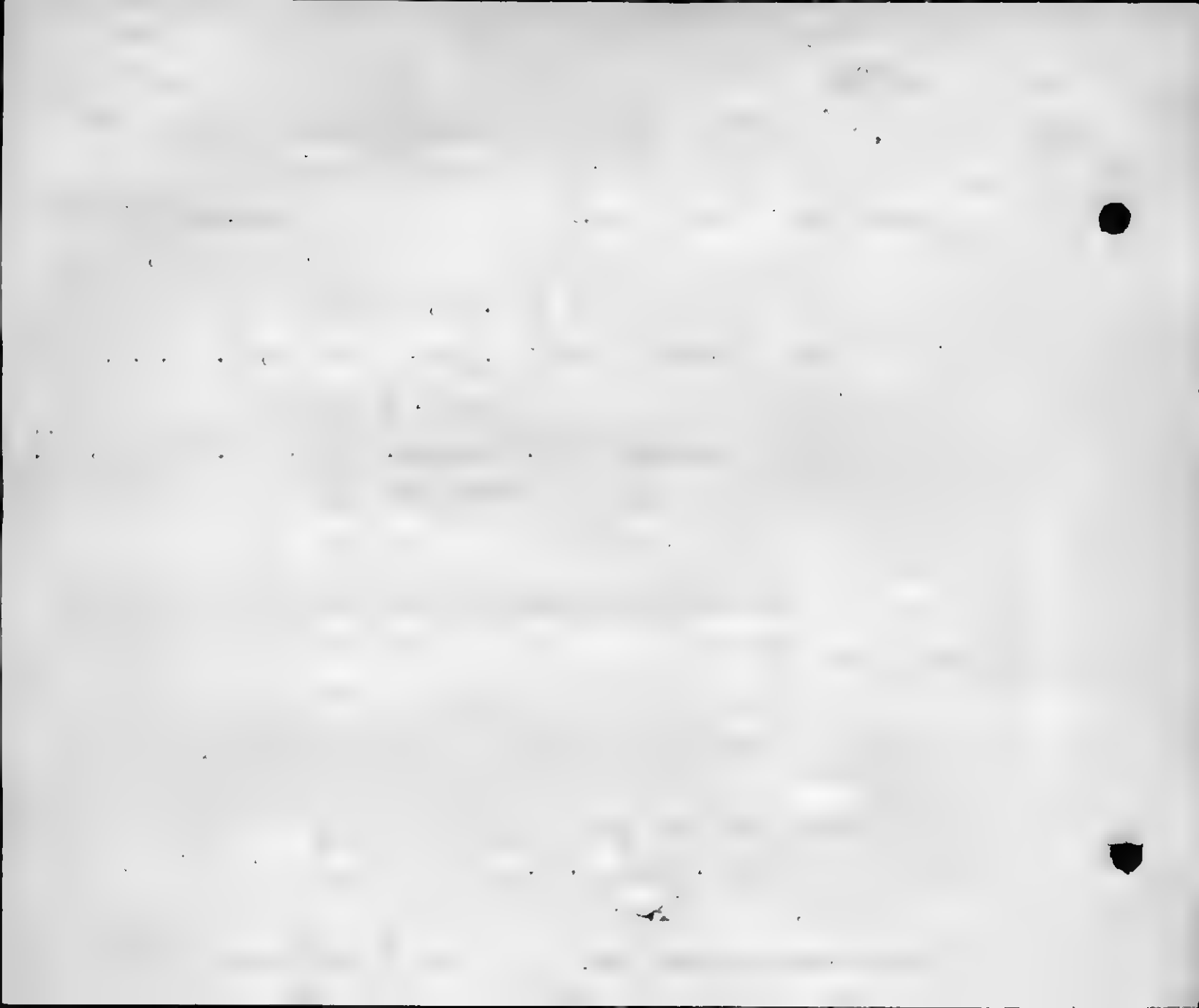
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01024

01016

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mount Rainier</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47 Mount Rainier</u>	
c. LENGTH OF STAY IN 1b <u>3 Years</u>		d. STREET ADDRESS <u>4301 Eastern Avenue Apt 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4301 Eastern Avenue Apt.1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS DAVIS GIBBONS</u>		4. DATE OF DEATH <u>January 1, 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1911</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Register. Stamardsville, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chastine Gibbons</u>		14. MOTHER'S MAIDEN NAME <u>Allie M. Startt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW II WW II</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Louisa G. Beach, Mt. Rainier, Md.</u>		Address <u>4701 25th St.,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Myocardial infarction</u>			
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery thrombosis</u>			
cause last, (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>January 1, 1961</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M. D.</u>		Address (Street, city, town, or county) <u>Arlington National</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 4, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>F Gasch's Sons Hyattsville Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



1
FOR STATE
HEALTH DEPT.

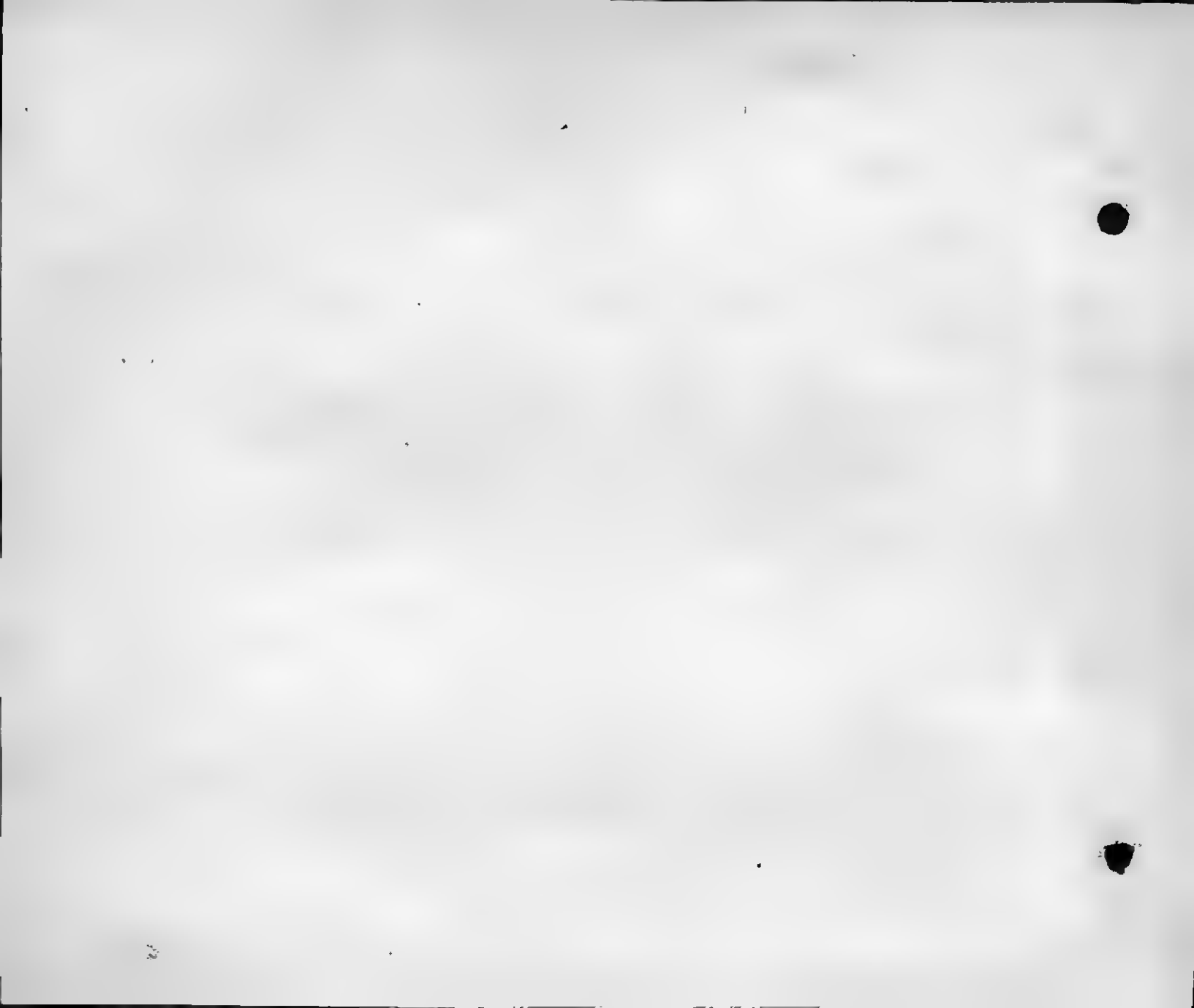
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aquasco				c. LENGTH OF STAY IN 1b Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aquasco			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural				d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Gray b. 6-6-00				4. DATE OF DEATH Month Day Year January 11 19 62							
5. SEX Male =		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 12, 1961		9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gray				14. MOTHER'S MAIDEN NAME Delorise Taylor							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Joseph Gray, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4-3X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/11/62			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/62		22c. NAME OF CEMETERY OR CREMATORY Haley & Santfield				22d. LOCATION (City, town, or county) Brandywine Maryland			
23. FUNERAL DIRECTOR George L. Kelson				ADDRESS Aquasco Md.				24a. REC'D BY REGISTRAR DATE JAN 15 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

2077171164



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)
(X)
(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

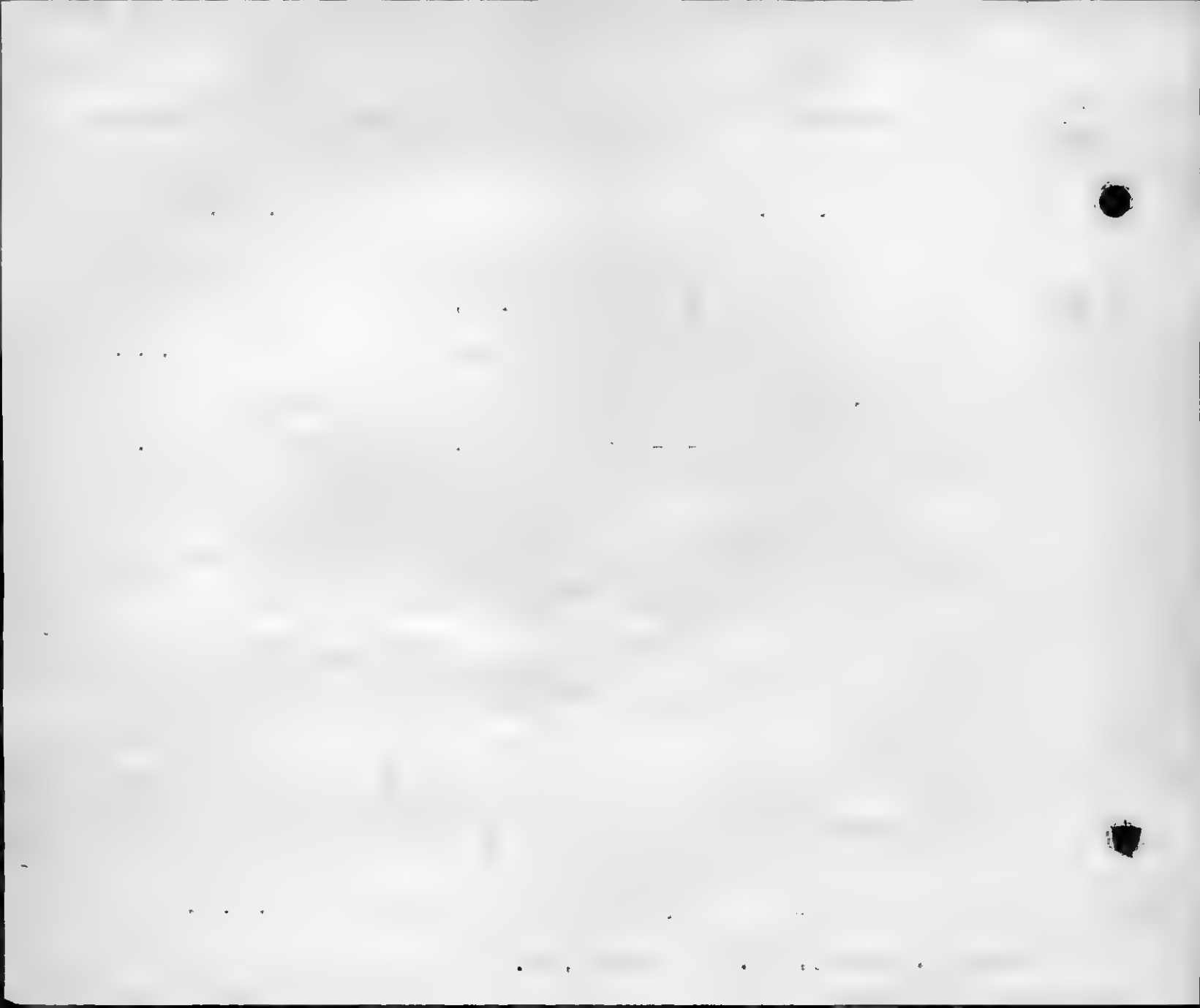
01026

CERTIFICATE OF DEATH

01018

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> c. LENGTH OF STAY IN TB <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4324 Rowalt Dr. Apt. #301</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> d. STREET ADDRESS <u>4324 Rowalt Dr. Apt. #301</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Florine Christine Grosskurth</u>		4. DATE OF DEATH <u>January 30 1962</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 12, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward S. White</u>				14. MOTHER'S MAIDEN NAME <u>Julia Miller</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>217-12-5943</u> 17. INFORMANT <u>Edward W. Grosskurth</u> Address <u>4324 Rowalt Dr. College Park</u>					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4-20-62</u> DUE TO (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15, 1962</u> to <u>Jan 30, 1962</u> that (I) <u> </u> last saw the deceased alive on <u>Jan 29, 1962</u> and that death occurred at <u>6:48 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Richard L. Whelton</u> M.D.		22b. DATE SIGNED <u>1-30-62</u>		22c. PHYSICIAN'S NAME (Type) <u>RICHARD L. WHELTON MD</u>		22d. ADDRESS <u>1021 University Blvd E Silver Spring Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

FEB 2 '62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

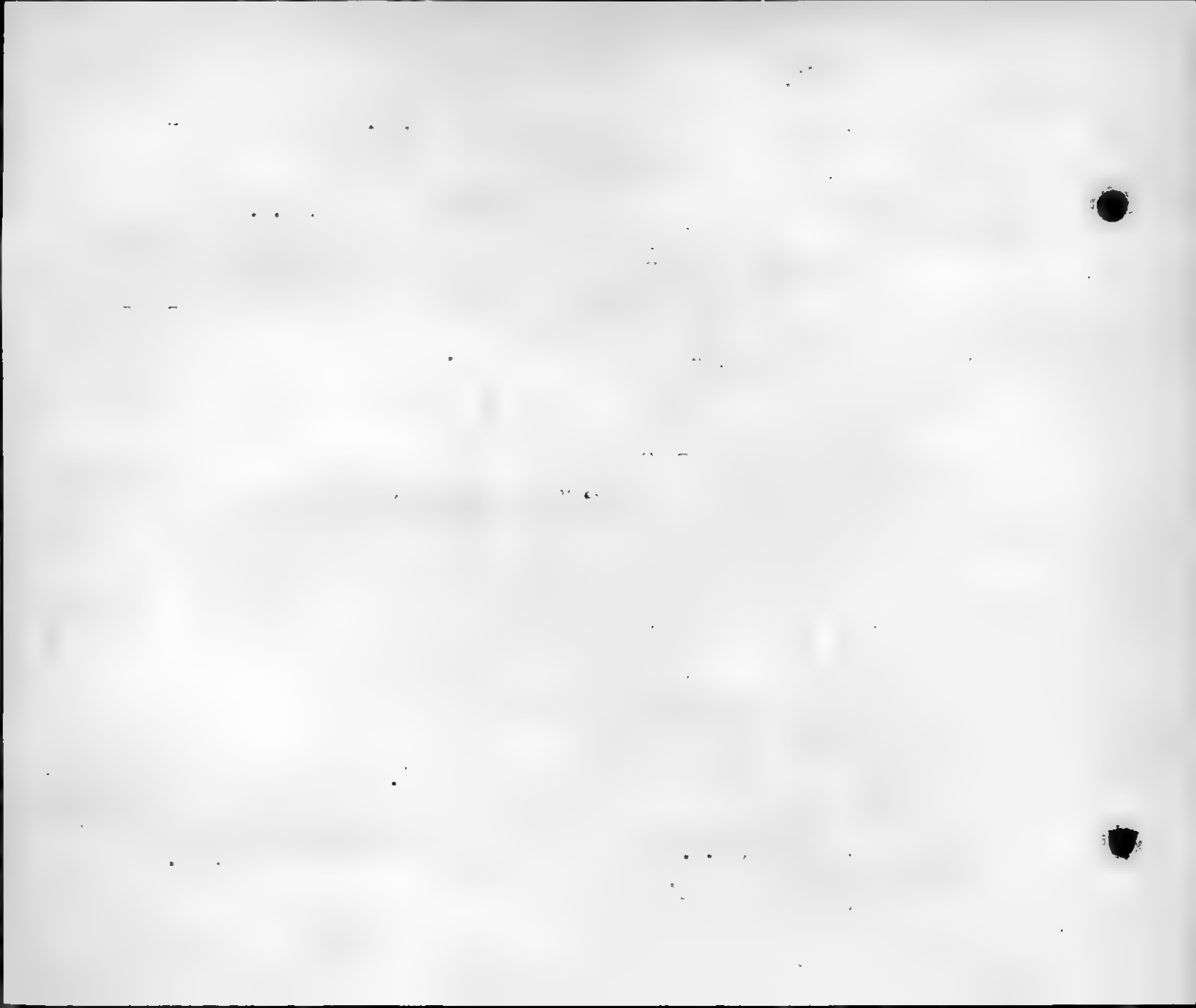
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01027

01019

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY IN 1b. <u>1 month and 24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glenn Dale Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47 X 3</u> d. STREET ADDRESS <u>1513 Meridian Place, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eddie</u> Middle <u>-</u> Last <u>Hampton</u>		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto-mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	9. AGE (In years last birthday) <u>66</u> yrs IF UNDER 1 YEAR: Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS: Hours <u>-</u> Min. <u>-</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee Hampton</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>578-12-2494</u>	
17. INFORMANT <u>Decedent</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Anaplastic (oat. cell) carcinoma, bronchogenic</u> <u>162.11</u> DUE TO <u>with metastases (right lung)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <u>-</u> (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>
21. I certify that (I) (this hospital) attended the deceased from <u>11/29/1961</u> to <u>1/22/1962</u> , that (I) (we) last saw the deceased alive on <u>1/22/1962</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Moe Weiss</u> M.D.		22b. DATE SIGNED <u>1/22/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M.D.</u>		22d. ADDRESS <u>Glenn Dale Hospital</u> <u>Glenn Dale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-29-62</u>	23b. DATE THEREOF <u>1-29-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brosnan & Allen 1200 E. ...</u>		25a. REC'D BY REGISTRAR <u>JAN 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>...</u>		25c. REGISTRAR'S SIGNATURE <u>...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

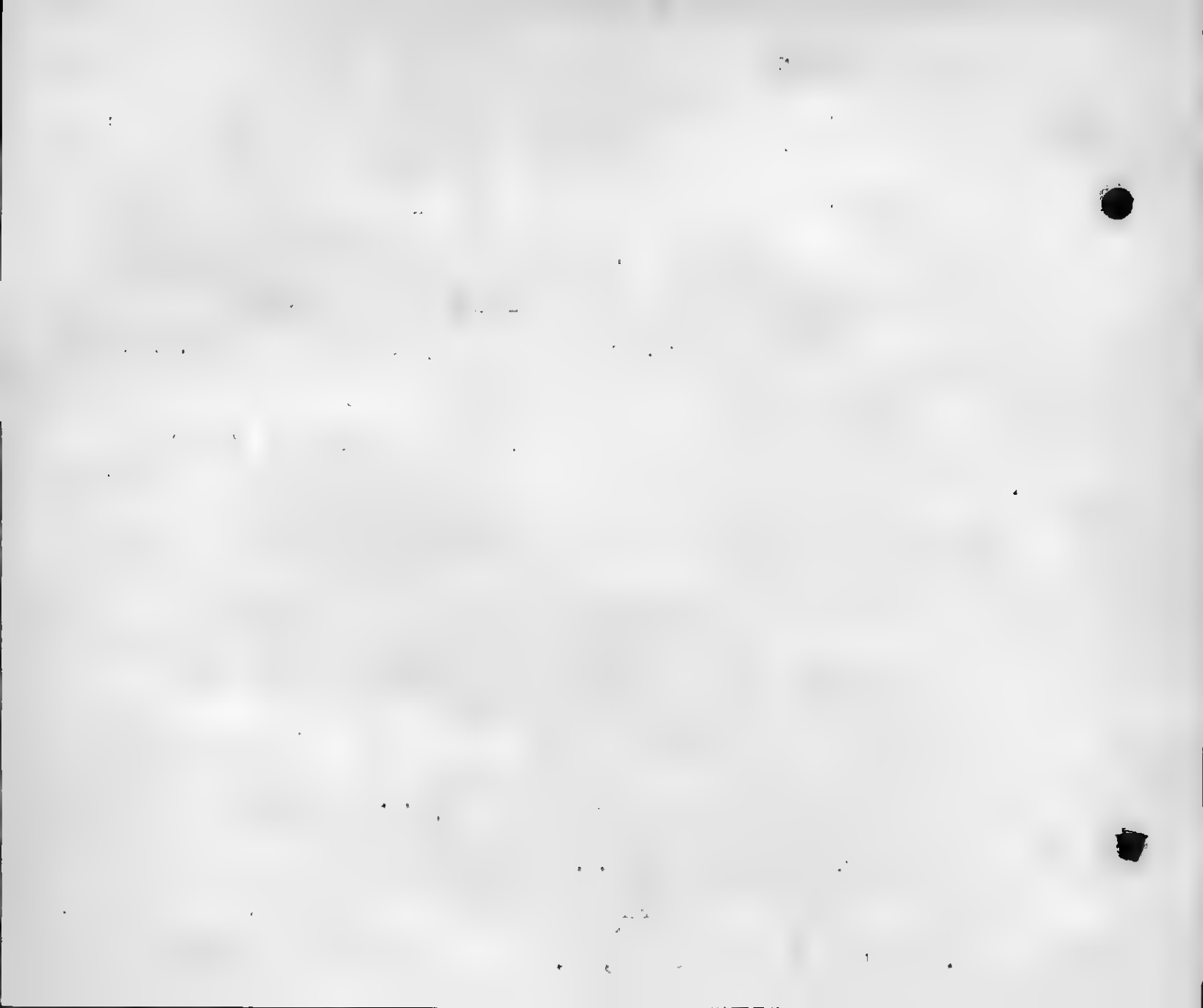
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01028

01020

1. PLACE OF DEATH e. COUNTY Prince George's b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Cheverly d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Bladensburg d. STREET ADDRESS 4105 - 53rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clayton P. Harley		4. DATE OF DEATH Month January Day 22 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-20-96		9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months 6 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired physiologist		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry Harley		14. MOTHER'S MAIDEN NAME Amanda Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Ida K. Harley Same as #2 (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: 1 57 X IMMEDIATE CAUSE (a) Hepatic Coma DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of the Head of the Pancreas DUE TO (c) unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) June 1960 to Jan 22, 1962		20g. (County) Prince George's		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Jan 22, 1962 , that (I) (we) last saw the deceased alive on Jan 21, 1962 , and that death occurred at 12:30 from the causes and on the date stated above.		22a. SIGNATURE William D. Rosson M.D. 22b. ADDRESS Dr. William D Rosson M.D.		22c. PHYSICIAN'S NAME (Type) Dr. William D Rosson M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/26/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington, Va.		24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24. ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE JAN 25 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01029

CERTIFICATE OF DEATH

01021

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Saint Francis Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2731 Nicholson St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Effie May Harris</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 9, 1888</u> 9. AGE (In years last birthday) <u>81</u> yrs. 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> 11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Summerville, Ind.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Thomas May</u> 14. MOTHER'S MAIDEN NAME <u>Ollie Caldwell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Nursing home records</u> Address _____					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> (b) <u>Cardiovascular disease</u> (c) <u>due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> <u>1962</u> to <u>1/27</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> <u>1962</u> , and that death occurred at <u>4</u> <u>PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl W. Graeff</u>		22b. DATE SIGNED <u>1/27/62</u>		22c. PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF</u>			
22d. ADDRESS <u>4114 Kirkwood Pl. N. Hyattsville, Md.</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elwood Cemetery</u>			
23d. LOCATION (City, town or county) <u>Elwood Indiana</u>		23e. FUNERAL DIRECTOR'S SIGNATURE <u>J. Paschke & General Home</u>					
25a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file them with the State Dept. of Health.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01030

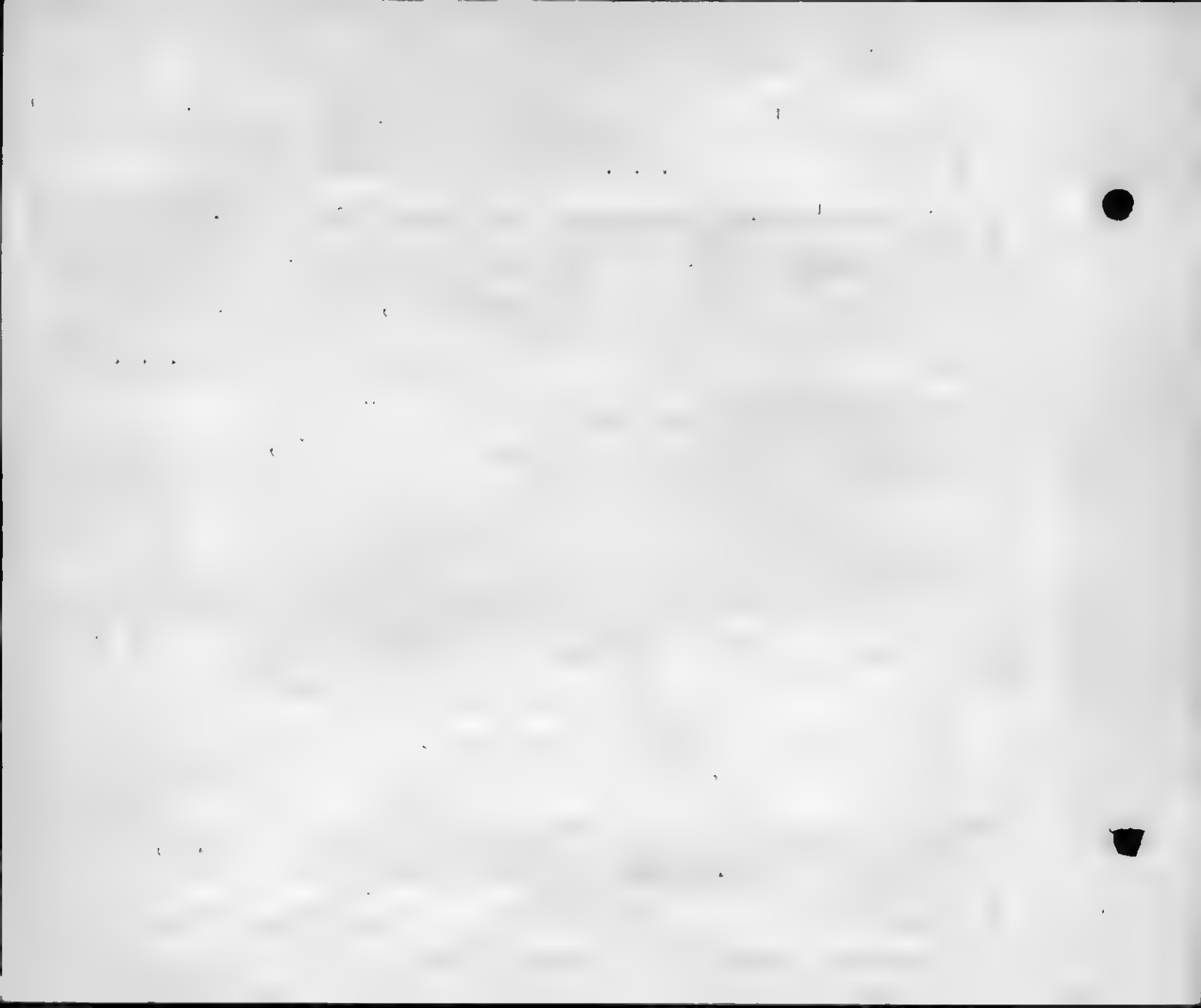
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01022

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C heverly c. LENGTH OF STAY in 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Riverdale d. STREET ADDRESS 6209 64th Avenue Apt. # 3	
3. NAME OF DECEASED (Type or print) Joseph Bart Heath		4. DATE OF DEATH January 26 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1961
9. AGE (in years last birthday) 1 23 1 23 1 23		10. AGE (in years last birthday) 1 23 1 23 1 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Virgil Charles Heath		14. MOTHER'S MAIDEN NAME Carolyn Ann Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Virgil Charles Heath, same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) 493X (c) 493X cause last. (c) 493X		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Jan. 26, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/29/62	
22c. NAME OF CEMETERY OR CREMATORY WASH NAT		22d. LOCATION (City, town, or country) (State) SUITLAND MD	
23. FUNERAL DIRECTOR WW CHAMBERS CO RIVERDALE MD		24a. REC'D BY REGISTRAR Jan 30 '62	
24b. REGISTRAR'S SIGNATURE William E. Hume			

2077182165



1
FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01031 01023

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale DOA

c. LENGTH OF STAY in lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution's Residence before admission)
e. STATE Maryland b. COUNTY Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 74 Beltsville

d. STREET ADDRESS 411220 Old Baltimore Road

3. NAME OF DECEASED (Type or print) John William Heflin

4. DATE OF DEATH January 11 19 62

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH June 24, 1886 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant 10b. KIND OF BUSINESS OR INDUSTRY Laboratory 11. BIRTHPLACE (State or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Heflin 14. MOTHER'S MAIDEN NAME Lena Cockrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs Mae V. Heflin, same as # 2 Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c)

CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED January 11, 1962

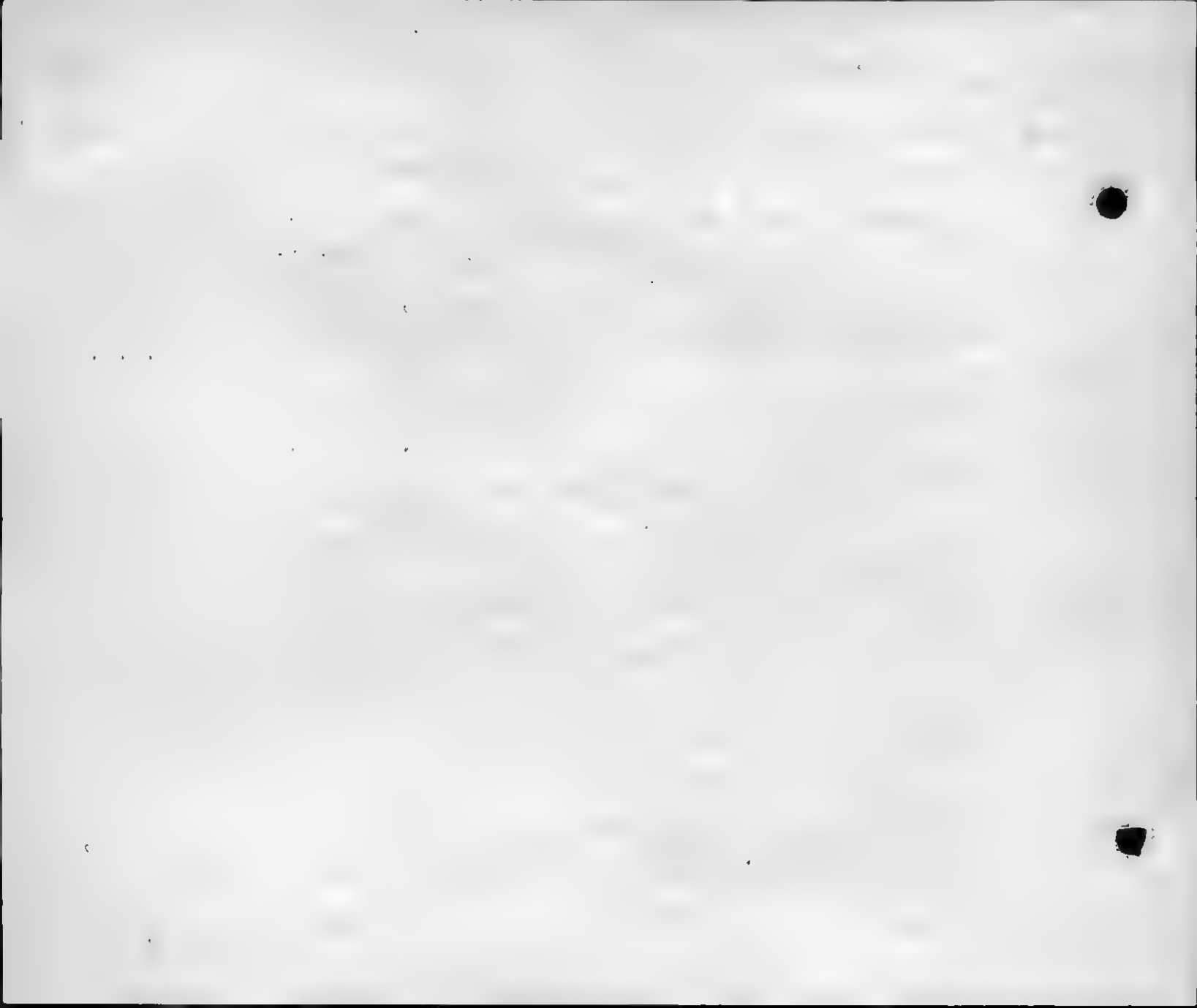
ACTUAL SIGNATURE James I. Boyd M.D. EXAMINER'S NAME (Type) James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1-15-1962 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem 22d. LOCATION (City, town, or country) Bladensburg, Maryland (State)

23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md. ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Hunt

DATE JAN 15 '62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7 61

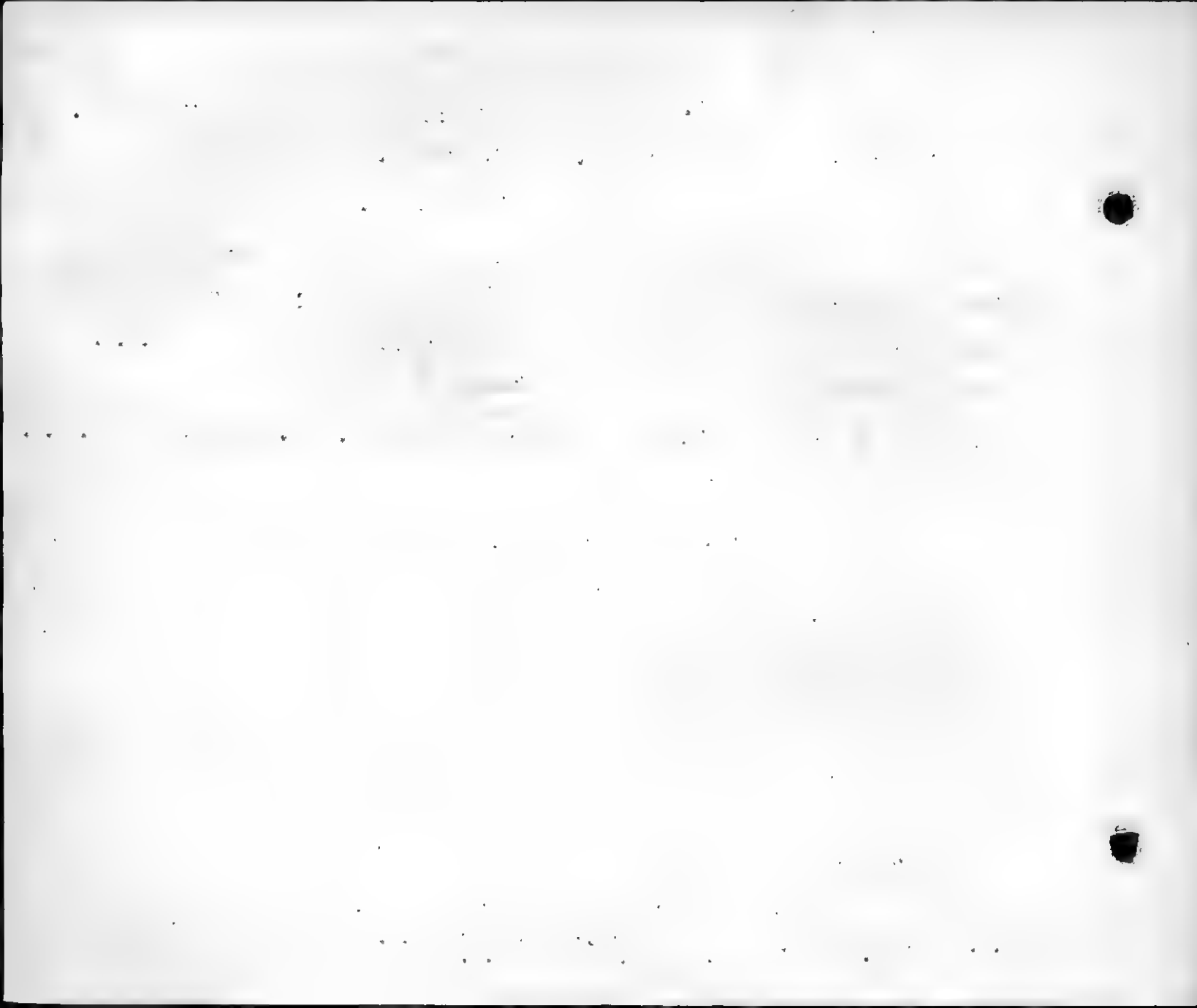
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
01032										
1. PLACE OF DEATH a. COUNTY Prince Georges					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					d. STREET ADDRESS 1209 1st St., S.E.					
3. NAME OF DECEASED (Type or print) George Charles Higdon					4. DATE OF DEATH 1 1 19 62					
5. SEX Male					6. COLOR OR RACE Negro					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 11/7/22					
9. AGE (in years last birthday) 39 yrs.					10. IF UNDER 1 YEAR Months Days 1 1					
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Hauling					12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Robert Contee Higdon					14. MOTHER'S MAIDEN NAME Ella Beal Higdon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown					16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Decedent					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver DUE TO Conditions, if any, which gave rise to immediate cause (b) Hepatic failure DUE TO (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month. Day, Year 19 1/1 1962										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/25/1961 to 1/1/1962, that (I) (we) last saw the deceased alive on 1/1/1962, and that death occurred at 10:10 A.M. from the causes and on the date stated above.										22b. DATE SIGNED 1/1/1962
22a. SIGNATURE Moe Weiss										22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland										22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 1-5-62
23c. NAME OF CEMETERY OR CREMATORY St. Paul Church Cemetery										23d. LOCATION (City, town or county) (State) Oxon Hill, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles A. Twine										25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
25c. ADDRESS 2500 - Nichols Ave. SE										DATE JAN 4 '62



01033

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES CO MD. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d STREET ADDRESS 4519 32nd St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alona G. Huntemann		4. DATE OF DEATH Month 1/30/62 Day 19 Year 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1870
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED R GENT		14. MOTHER'S MAIDEN NAME RACHAEL T TAYLOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #### (If yes, give war or dates of service) #####		16. SOCIAL SECURITY NO. #####	
INFORMANT WILLSON K HUNTEMANN. SON.		Address 1400 MEMLOCK ST. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia Edema 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension			
INTERVAL BETWEEN ONSET AND DEATH 6 days 31 years 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2-62 , to 1-30-62 that I last saw the deceased alive on 1-30-62 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Petry St. DATE SIGNED 1-30-62			
ACTUAL SIGNATURE Waldo B. Moyers M.D. Wald B. Moyers			
PHYSICIAN'S NAME (Type) Waldo B. Moyers Mt Rainier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/3/62	
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.K. HUNTEMANN & SON		24b. REGISTRAR'S SIGNATURE W.K. Huntemann & Son	
ADDRESS 5732 GEORGIA AVE. N.E.W.		DATE FEB 2 '62	

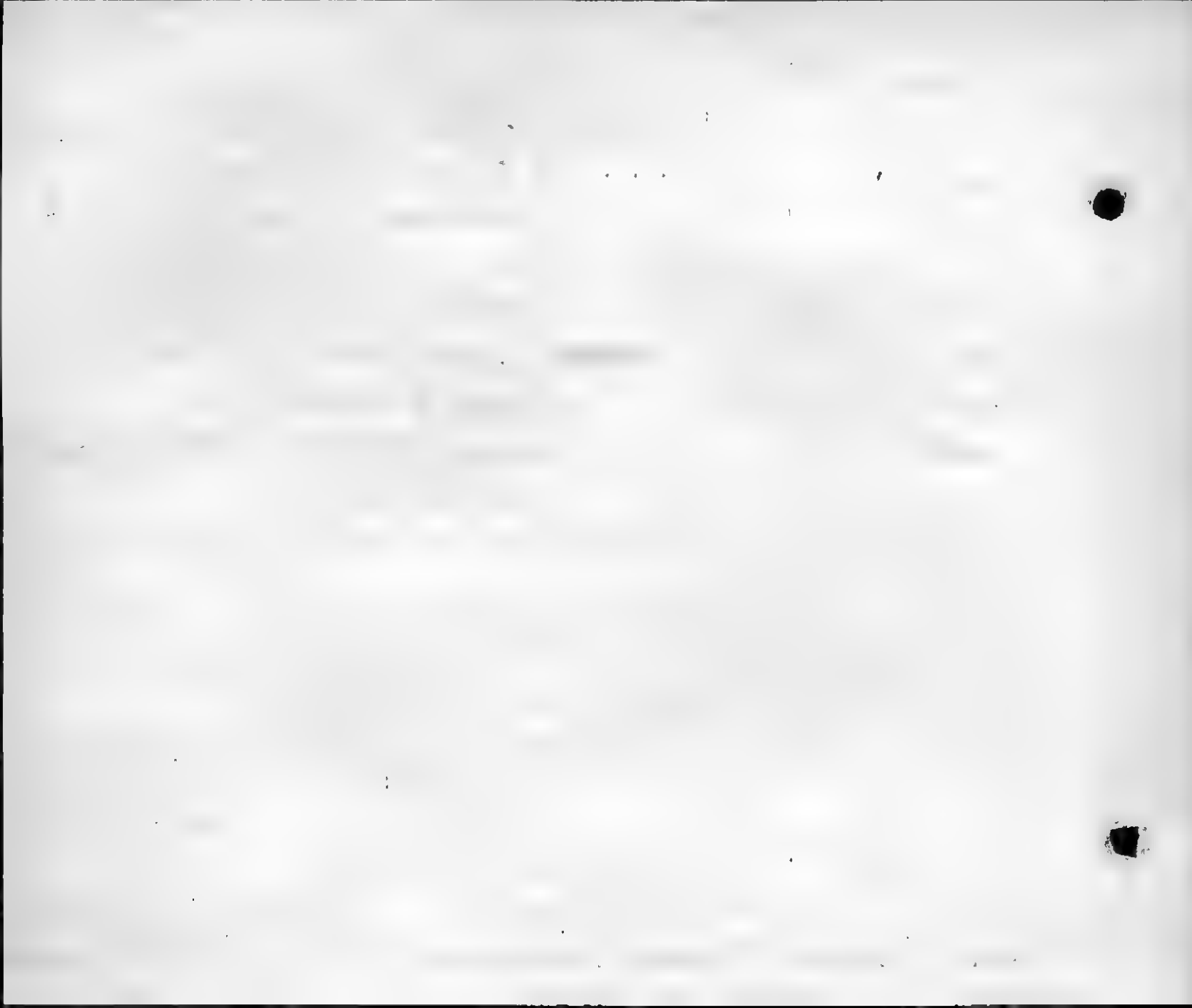
VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01034
CERTIFICATE OF DEATH
01026

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 th DISTRICT HEIGHTS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 7007-WALKER MILL ROAD	
3. NAME OF DECEASED (Type or print) Eva MAY Jenkins		4. DATE OF DEATH January 29 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1878
9. AGE (In years last birthday) 83 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		12. KIND OF BUSINESS OR INDUSTRY AT HOME	
13. FATHER'S NAME THOMAS E LYNCH		14. MOTHER'S MAIDEN NAME MARY O THOMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT THELMA I KASULKE		Address DISTRICT HEIGHTS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure (b) Cardiovascular renal disease (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 40 to January 29, 1962 (I) (we) last saw the deceased alive on Jan 29 19 62 and that death occurred at 3:30 PM the causes and on the date stated above.			
22a. SIGNATURE James I. Boyd		22b. DATE SIGNED 1/29/62	
22c. PHYSICIAN'S NAME James I. Boyd		22d. ADDRESS Forestville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/2/62	
23c. NAME OF CEMETERY OR CREMATORY EPIPHANY		23d. LOCATION (City, town or county) FORESTVILLE MD	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO WASHINGTON DC		25a. REG'D BY REGISTRAR FEB 5 62	
25b. REGISTRAR'S SIGNATURE Anthony J. Thomas		25c. DATE	



1. THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

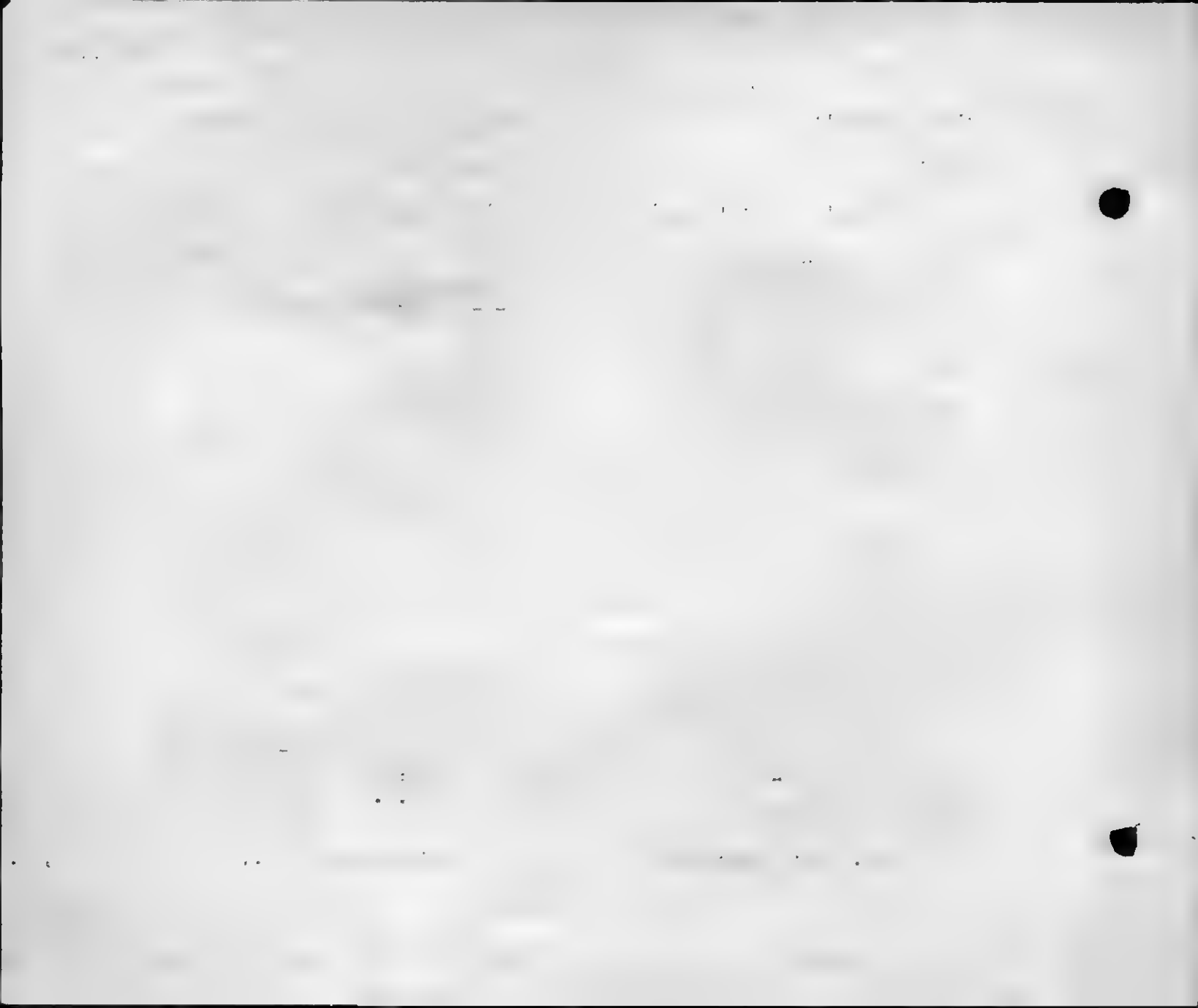
CERTIFICATE OF DEATH

02236

01035 Items 8 & 9 10a, 11, 12 13 & 14 Film G307 2/13/62 ink

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks	
c. LENGTH OF STAY in lb 7 days		d. STREET ADDRESS 1106 54th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			
3. NAME OF DECEASED (Type or print) Frances Jewell		4. DATE OF DEATH January 29 1962	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DAY 10/1/1910 E (In year birthdate) 1/13/45 MONTH 12 DAY 15 YRS. 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Georgia	
13. FATHER'S NAME Henderson Cross		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from 1-29-1962 to 1-29-1962 , that (I) (we) last saw the deceased alive on 1-29-1962 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.		
22a. SIGNATURE Barry Rosenberg M.D. 22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg		22b. DATE SIGNED 1/31/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-62
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City, town or county) (State) Suitland Rd. Md.
24. PHYSICIAN DIRECTOR'S SIGNATURE R. L. Crouch ADDRESS 51-Kay St. N.W.		25a. REC'D BY REGISTRAR DATE FEB 7 '62 25b. REGISTRAR'S SIGNATURE Gail H. Thomas



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the delay in the "Remarks" section. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01036 01027											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lemuel Arthur Judd						d. STREET ADDRESS Fairmount Heights 600 60th Ave.					
5. SEX Male						4. DATE OF DEATH January 31, 1962					
6. COLOR OR RACE Colored						7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					
8. DATE OF BIRTH December 23, 61						9. AGE (In years last birthday) 1 8 8					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None						10b. KIND OF BUSINESS OR INDUSTRY None					
11. BIRTHPLACE (State or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ralph Judd						14. MOTHER'S MAIDEN NAME Dorothy Nichols					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT Ralph Judd						Address Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 1/31/62											
ACTUAL SIGNATURE James I. Boyle M.D.											
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-3-62											
22b. DATE THEREOF 2-3-62											
22c. NAME OF CEMETERY OR CREMATORY Lincoln Men											
22d. LOCATION (City, town, or country) (State) Suitland Rd Md											
23. FUNERAL DIRECTOR Henry Washington Sava ADDRESS 4925 Deane Ave NE											
24a. REC'D BY REGISTRAR FEB 5 '62											
24b. REGISTRAR'S SIGNATURE John P. H.											

2077235166



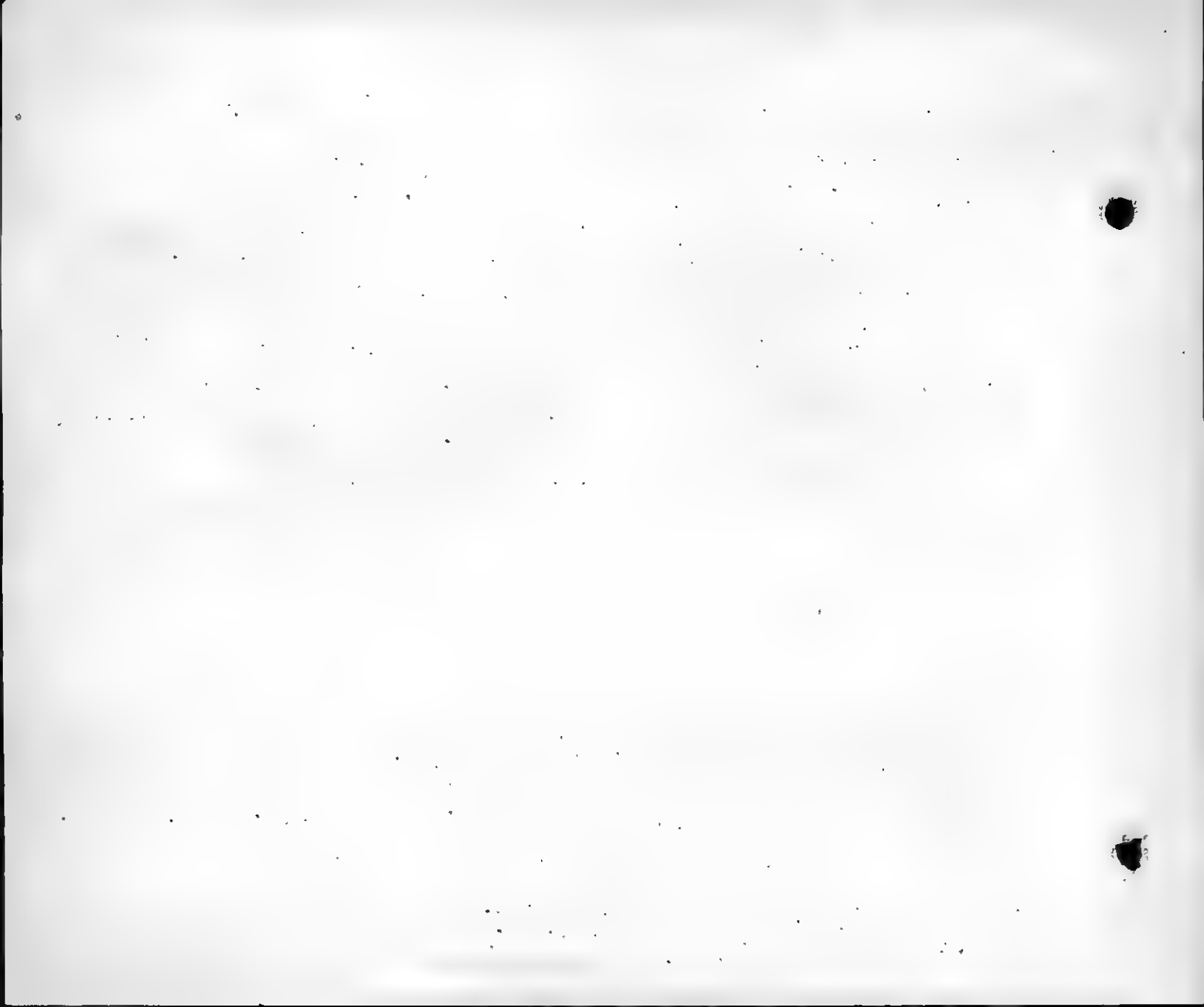
01037

CERTIFICATE OF DEATH

Reg. Dist. No. 01028

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum 49</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5416-15th Avenue</u>		d. STREET ADDRESS <u>5416-15th Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Cecelia</u> Middle <u>M.</u> Last <u>Kehoe</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>2nd</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Brooklyn N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph Roldan</u>	
14. MOTHER'S MAIDEN NAME <u>Dolores James</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Edward Kehoe</u>		17. INFORMANT Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Right Lung</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Aug 22 1961</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/13/61</u> , 19 <u> </u> , to <u>1/2/62</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12/26/61</u> , 19 <u> </u> , and that death occurred at <u>9 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Sweeney MD</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1238 Monroe St NE 1, 2/62</u>	
PHYSICIAN'S NAME (Type) <u>John J. Sweeney MD</u>		DATE SIGNED <u>1/2/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/6/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rainier</u>	22d. LOCATION (City, town, or county) (State) <u>Washington St.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		24. REC'D BY REGISTRAR DATE <u>JAN 9 '62</u>	
ADDRESS <u>Mt. Rainier Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01038
CERTIFICATE OF DEATH
01029

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>4811 Odell Road</u>	
3. NAME OF DECEASED (Type or print) <u>Maurice Edgar Kelley</u> First Middle Last 4. DATE OF DEATH <u>Jan. 19 1962</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-03</u> 9. AGE (In years last birthday) <u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior Poultry Aid Agr Research</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Centex Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Louise Ruperty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Deceased</u>	
17. INFORMANT <u>Above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 20.0 DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerosis</u> (c) <u>HT Des 7 Mo</u> DUE TO cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depressed reaction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 19 1961</u> to <u>Jan 19 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 19 1962</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>LW Malen</u> M.D.		22b. DATE SIGNED <u>Jan 19 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>LW Malen MD</u>		22d. ADDRESS <u>Buena Vista, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Hasch's Sons</u>		25a. REC'D BY REGISTRAR <u>Jan 24 '62</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. Kiser</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01039

01030

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>405 Gorman Avenue</u>		d. STREET ADDRESS <u>405 Gorman Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Elmira Mae</u>		4. DATE OF DEATH <u>January 12 1962</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 9, 1889</u> 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. FATHER'S NAME <u>John Baughitts</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Mary Joyce</u>	
15. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bladder - Metastasis</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes - Hypertension</u> (c), stating the underlying cause last. <u>Cardiovascular</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>61</u> , to <u>1/12</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/12</u> , 19 <u>62</u> and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B.P. Warren</u>		22b. DATE SIGNED <u>1/13/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.P. WARREN</u>		22d. ADDRESS <u>Laurel, Md</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 1/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cemetery</u>	
23d. LOCATION (City, town or county) <u>Laurel, Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford S. Kram</u>		25a. REC'D BY REGISTRAR <u>Clifford S. Kram</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 16 '62</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01040

01031

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover Hills d. STREET ADDRESS 7109 Varnum Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James C. Kirkpatrick				4. DATE OF DEATH January 11 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-1886	
9. AGE (in years last birthday) 75 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Horseman		11. BIRTHPLACE (County & State, or foreign country) Hamilton, Canada	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Neil Kirkpatrick			
14. MOTHER'S MAIDEN NAME Elizabeth Sullivan				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			
16. SOCIAL SECURITY NO. Anna M. Kirkpatrick (above address)				17. INFORMANT Address Anna M. Kirkpatrick (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis - estimated 8 yrs. - (c) Uremia INTERVAL BETWEEN ONSET AND DEATH 1 week PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1960, to Jan. 11, 1962, that (I) (we) last saw the deceased alive on Jan. 10, 1962, and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas G. Maloney M.D.				22b. DATE SIGNED Jan 17 '62			
22c. PHYSICIAN'S NAME (Type, THOMAS G. MALONEY M.D.				22d. ADDRESS 4814-71st Ave. Landover Hills Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/15/1962		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Church of the Ascension Cem.		23d. LOCATION (City, town or county) (State) Bowie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home, Inc.				25a. REC'D BY REGISTRAR DATE JAN 17 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Brown				25c. REGISTRAR'S NAME			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



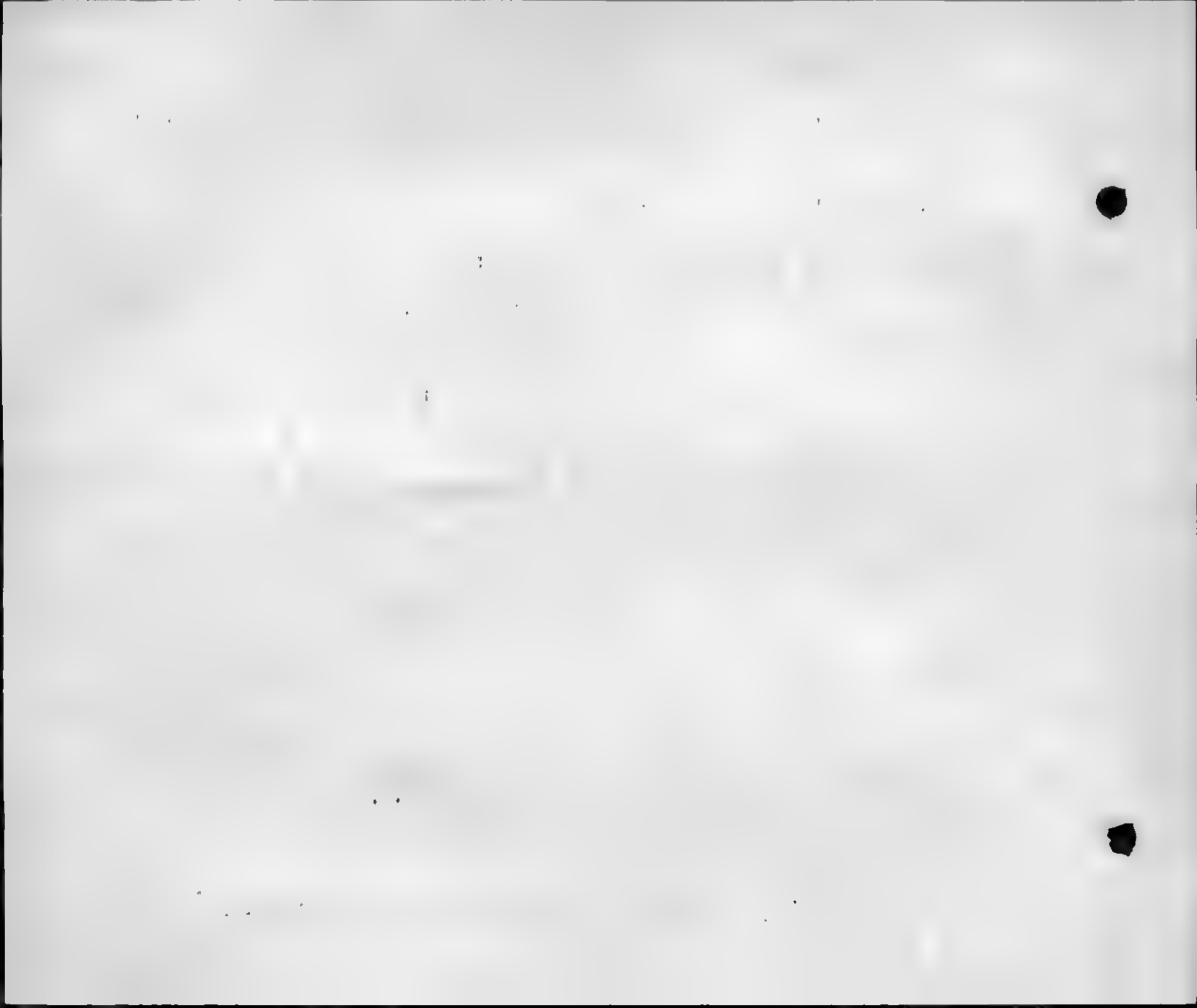
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>01041</div> <div>01032</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>4710 Queensbury Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>INFANT, BABY BOY</u> First <u>U</u> Middle <u>L</u> Last <u>Lamoureux</u>					4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>19 62</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 10, 1962</u>		9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Bernard R. LAMOREUX</u>					14. MOTHER'S MAIDEN NAME <u>Carol R MORSE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>NONE</u>				
17. INFORMANT <u>BERNARD R. LAMOREUX</u> Address <u>SAME AS #2</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Bilateral Pulmonary Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature</u> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>3:55</u> a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> to <u>1/12</u> , 1962, that (I) (we) last saw the deceased alive on <u>1/12</u> , 1962, and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Gloria D. Eng</u>					22b. DATE SIGNED <u>3:55 P.M.</u>				
22c. PHYSICIAN'S NAME (Type) <u>GLORIA D. ENG</u>					22d. ADDRESS <u>6607 RIVERDALE RD., RIVERDALE, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN 22, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARTLAND CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>E. HARTLAND, CONNECTICUT.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>					25a. REC'D BY REGISTRAR <u>DATE JAN 23 '62</u>				
25b. REGISTRAR'S SIGNATURE <u>William S. Finna</u>									



1
FOR STATE
HEALTH DEPT.

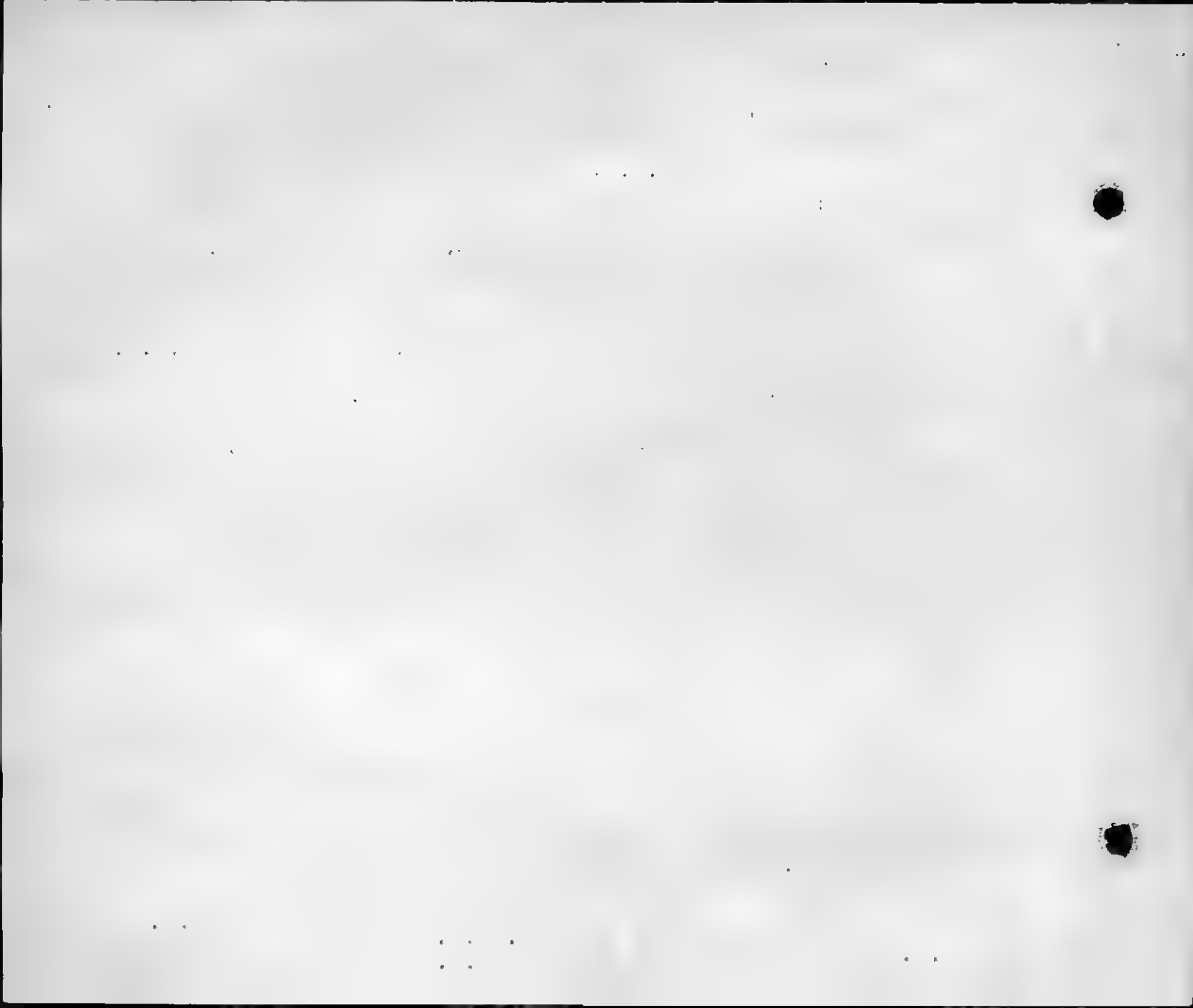
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01033

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) University Park		
c. LENGTH OF STAY in 1b D.O.A.			d. STREET ADDRESS 4412 East West Highway		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles Harrison Lederer			4. DATE OF DEATH Month January Day 24 Year 1962		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 6, 1888		
9. AGE (in years last birthday) 73			10. IF UNDER 1 YEAR Months 7 Days 18		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk			10b. KIND OF BUSINESS OR INDUSTRY Retired		
11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Phillip Lederer			14. MOTHER'S MAIDEN NAME Caroline Gleisner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 578-05-0811		
17. INFORMANT Virginia Walton Lederer, same as # 2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congest heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease (c) DUE TO (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James I. Boyd			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial			22b. DATE THEREOF 1/27/62		
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			22d. LOCATION (City, town, or country) (State) Washington, D.C.		
23. FUNERAL DIRECTOR The S.H. Hines Company			24a. REC'D BY REGISTRAR 1/29/62		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

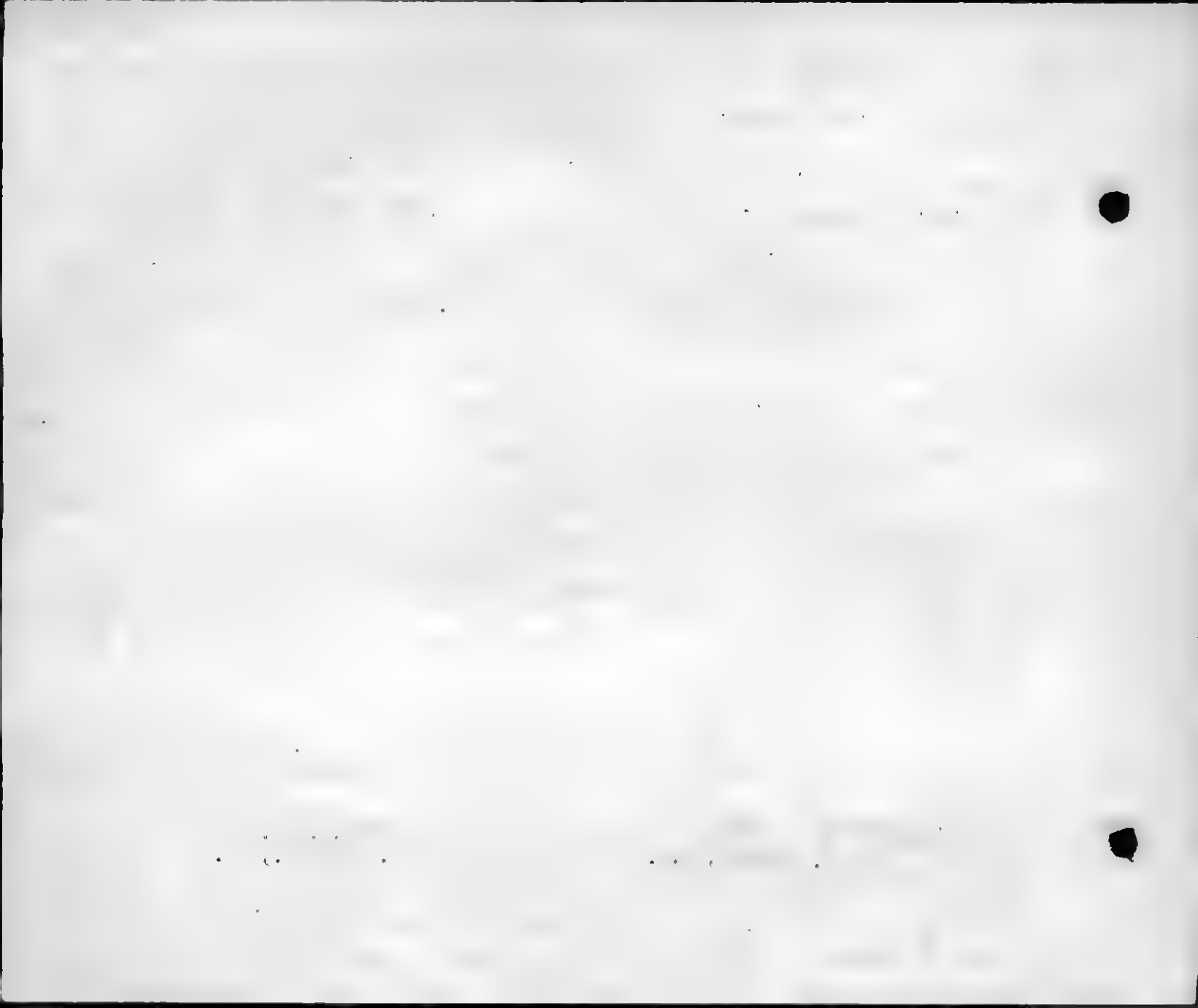
CERTIFICATE OF DEATH

01043

01034

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY in b. 20 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Res. before admission) e. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3924 Livingston Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mamie Lewis 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 14 oct. 1876 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON DC 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH OLIVERI 14. MOTHER'S MAIDEN NAME FRANCES DI MARZO			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT JOSEPH E LEWIS GREENBELT MD				Address 204 RIDGE ROAD INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 days 16 hrs			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600:0 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) renal failure (c) anemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 7 19 Hour a.m. 7 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 1957, 19, to 11/27, 1962 21. I certify that (I) (this hospital) attended the deceased from 1/27, 1962, that (I) (we) last saw the deceased alive on 1/27, 1962, and that death occurred at 6:50 AM, the causes and on the date stated above. 22. SIGNATURE Dr. L. Levitsky, M.D. 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 3408 R.I. Ave. Mt. Rainier, Md. 22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 1/30/62 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL 23d. LOCATION (City, town or county) (State) SUITLAND MD		24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers 25. REC'D BY REGISTRAR DATE JAN 30 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

M

17

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

01044
01055
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

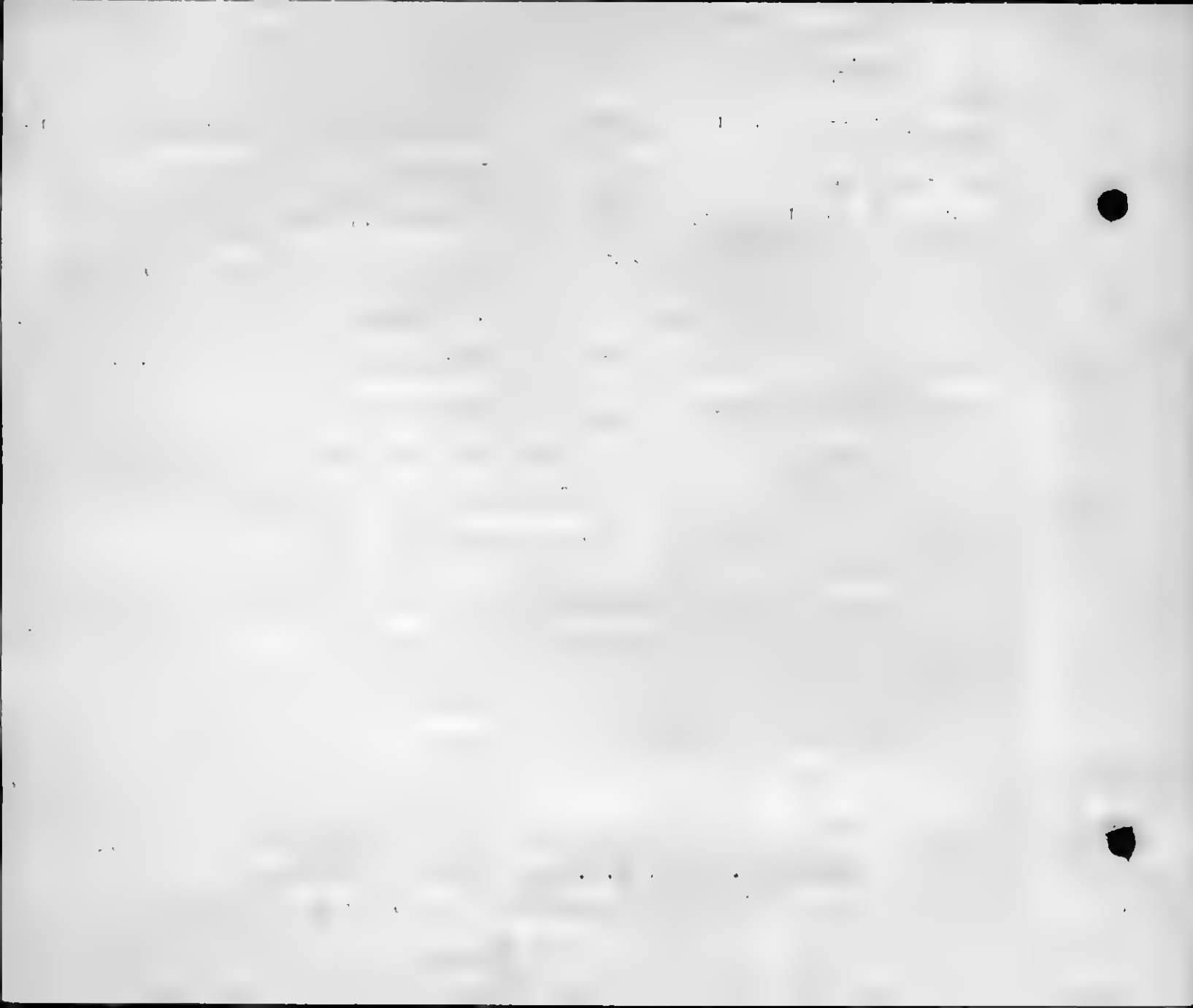
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>9113 7th. Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lyell Earl Luck</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26, 1898</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Excavator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Jefferson Luck</u>				14. MOTHER'S MAIDEN NAME <u>Addie Jane Pugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mary Elizabeth Luck</u>				Address <u>Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <u>W. W. Chambers & Co</u>				24a. REC'D BY REGISTRAR <u>8</u> '62			
24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers & Co</u>				DATE SIGNED <u>1/4/62</u>			

MEDICAL CERTIFICATION

James I. Boyd, M.D.
James I. Boyd, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED
1/4/62



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01045 01036

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Carrollton
d. STREET ADDRESS 8303 Quilton Street

3. NAME OF DECEASED (Type or print) Harry Charles Manning
4. DATE OF DEATH January 5 19 62
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Oct. 1, 1917
9. AGE (In years last birthday) 44 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) District of Columbia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry Manning 14. MOTHER'S MAIDEN NAME Houston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 16. SOCIAL SECURITY NO. WW II 17. INFORMANT Eileen Ida Manning, same as # 2 Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
442X DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease
(c) Cardiovascular renal disease
cause last. (c) DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part I. of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

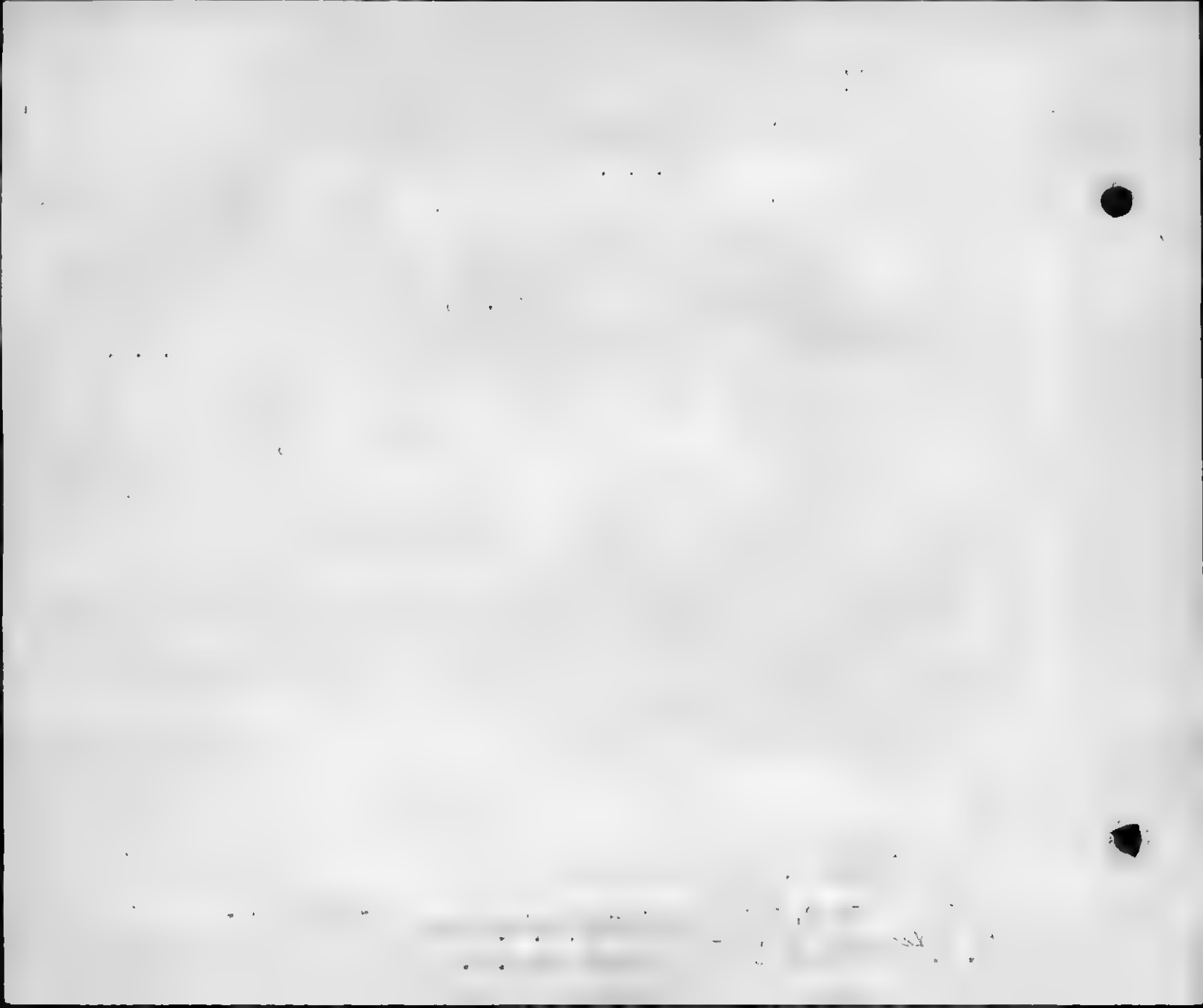
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED January 6, 1962
EXAMINER'S NAME (Type) James I. Boyd Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Jan 9, 1962 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 22d. LOCATION (City, town, or country) (State) Arlington Va.

23. FUNERAL DIRECTOR W. K. Huntemann & Son 24b. REGISTRAR'S SIGNATURE W. K. Huntemann & Son 24c. REGISTRAR'S SIGNATURE W. K. Huntemann & Son 5732 Georgia Ave N. W. DATE JAN 8 '62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 of this Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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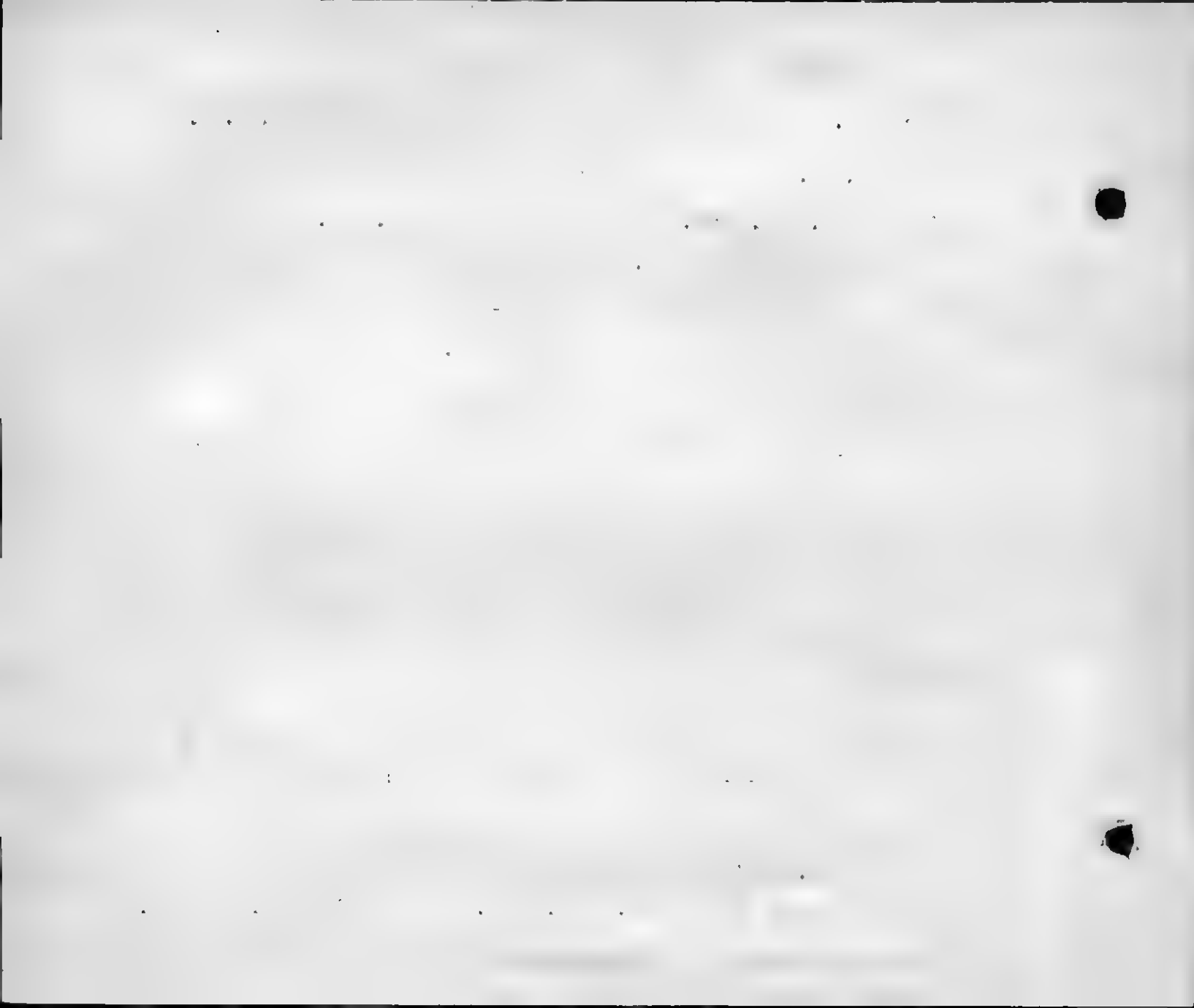
VR A15 (4)
ISM 9/60

01046

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01037

1. PLACE OF DEATH a. COUNTY Prince Geo. County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE (Washington 27, D. C.) b. COUNTY D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hosp.		d. STREET ADDRESS 1228 55th. Ave.	
3. NAME OF DECEASED (Type or print) Virginia S. Margelos		4. DATE OF DEATH 1-6-62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH 1-5-01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Va.	
11. BIRTH PLACE (Country & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh Grimm		14. MOTHER'S MAIDEN NAME Jennie Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT George Margelos		Address Same #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 44-27 DUE TO Conditions, if any, which gave rise to immediate cause (b) Congestive heart failure a), stating the underlying cause last, (c) Hypertensive cardiac vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Anemia		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years 10 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-31-61 19....., to 1-6-62 19....., that (I) (we) last saw the deceased alive on 1-6-62 19....., and that death occurred at 8:40 PM the causes and on the date stated above.			
22a. SIGNATURE R.D. BAYER M.D.		22b. DATE SIGNED 1-7-62	
22c. PHYSICIAN'S NAME (Type) R.D. BAYER M.D. Med. Staff		22d. ADDRESS Prince George's Gen. Hospital, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 Jan '62	
23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem.		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25. REC'D BY REGISTRAR Washington D.C.	
25a. REGISTRAR'S SIGNATURE Arthur S. Kenna		25b. DATE JAN 11 '62	



1
FOR STATE.
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give legal age in item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

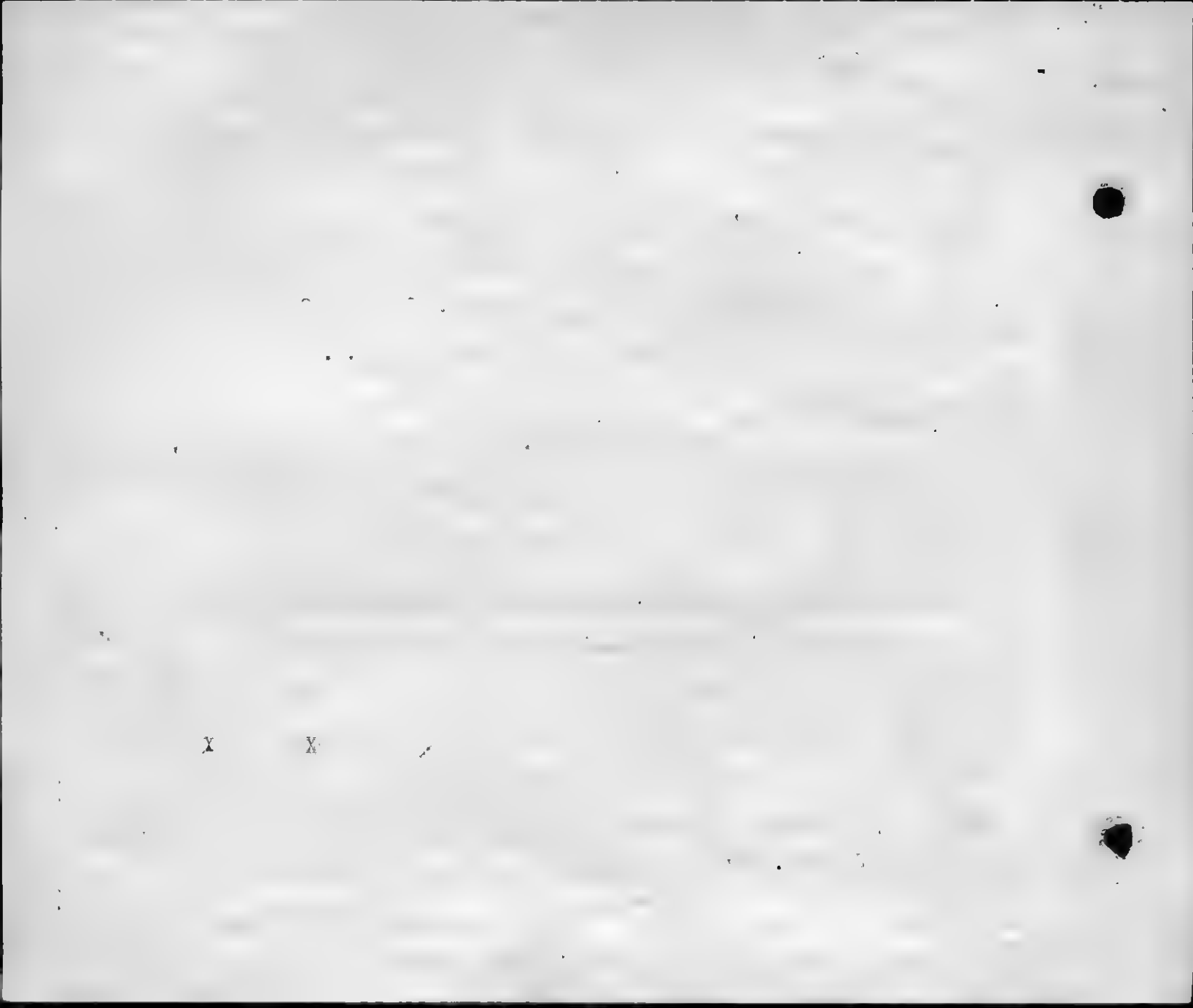
1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01047 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01038

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS c. LENGTH OF STAY in 1b 4 HOURS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS, ANDREWS AFB MD				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELALTON d. STREET ADDRESS BOX #83 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First MARY		Middle HELEN		Last MCCARTER	
4. DATE OF DEATH JANUARY 19 19 62		Month JANUARY		Day 19		Year 19 62	
5. SEX FEMALE		6. COLOR OR RACE NEGRO/ID		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 FEB 1923	
9. AGE (in years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN L THOMPSON				14. MOTHER'S MAIDEN NAME MARY SWANN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 577-24-9067		17. INFORMANT MRS. MARY THOMPSON BOX 83 BELALTON, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED FULMINATING PURPURA DUE TO (b) SEVERE THROMBOCYTOPENIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATTY INFILTRATION LIVER 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 20 Jan 62 Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-26-62		22c. NAME OF CEMETERY OR CREMATORY ST IGNATIUS		22d. LOCATION (City, town, or country) (State) BEL ALTON, MD.	
23. FUNERAL DIRECTOR The Hunt + Funeral Home, WALDORF, MD.				24a. REC'D BY REGISTRAR JAN 30 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Plummer</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

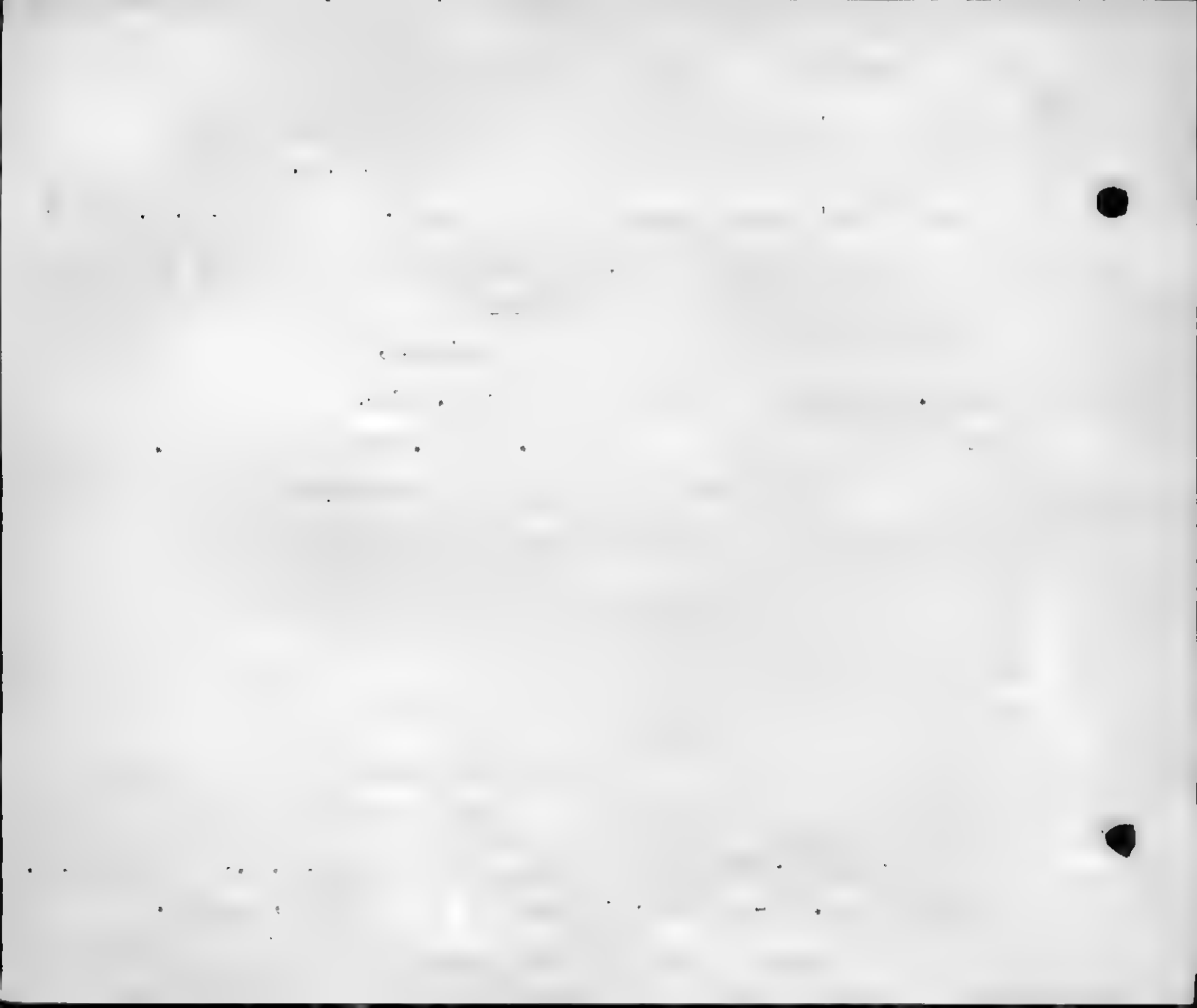
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01048

01039

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY V c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 3014 So. Dakota Avenue, N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William F. McDonald 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8-7-09 9. AGE (in years last birthday) 52 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Agent 11. BIRTH-PLACE (County & State, or foreign country) Washington, DO 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John W. McDonald 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Ethel P. Holmes Address Same as # 2.		14. MOTHER'S MAIDEN NAME Mary E. Holmes 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Abdominal Carcinomatosis DUE TO (b) Adenocarcinoma sigmoid colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct 25, 1961, to Jan 19, 1962, that (I) (we) last saw the deceased alive on Jan 8, 1962, and that death occurred at 2:40 PM from the causes and on the date stated above. 22a. SIGNATURE Harry N. Carlton, M.D. 22b. DATE SIGNED Jan 19 1962 22c. PHYSICIAN'S NAME (Type) Dr. Harry N. Carlton ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 940 25th Street, N. W., Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan. 22 -62 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City, town or county) Suitland, Maryland. (State)		24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661 Good Hope Rd ADDRESS 25a. REC'D BY REGISTRAR JAN 22 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department, Baltimore 1, Maryland, for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01049 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Raleigh			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9207 6th Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beckley			
f. STREET ADDRESS 106 Reservation Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Andrew Last McGuire				4. DATE OF DEATH Month January Day 26 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month March Day 31 Year 1900	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McGuire				14. MOTHER'S MAIDEN NAME UNKNOWN - ELIZABETH KAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 234-10-8919			
17. INFORMANT Thayard Andrew McGuire, same as #1				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease (c) Coronary artery disease DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED January 26, 1962			
EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 29, 1962		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Beckley, W. Virginia	
23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR JAN 31 '62		24b. REGISTRAR'S SIGNATURE Carlton S. Thomas	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76

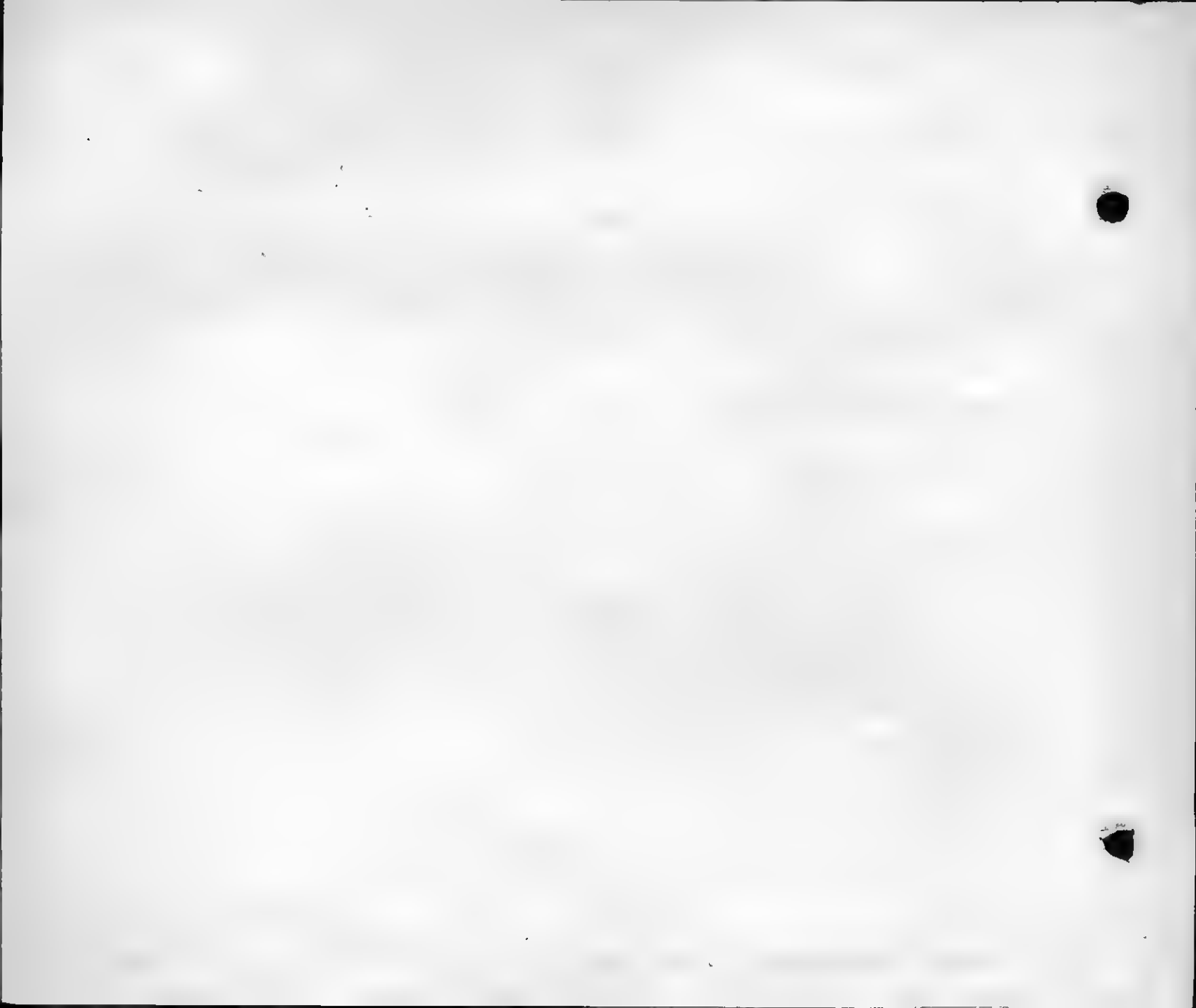
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01050

01041

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Truett Hospital</u> <u>4408 Queensbury Rd. - Riverdale, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u> d. STREET ADDRESS <u>7106 Poplar Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Wayne Lewis Meadows Jr.</u>		4. DATE OF DEATH Last <u>1</u> Month <u>17</u> Day <u>19</u> Year <u>62</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-62 5:35 am</u>	9. AGE (in years last birthday) <u>4</u> yrs.	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> Hours <u>19</u> Min. <u>62</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Wayne Lewis Meadows</u>		14. MOTHER'S MAIDEN NAME <u>Amy Clark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wayne S Meadows</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>prematurely</u> (a), stating the underlying cause last, DUE TO (c) _____ PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Hour a.m. _____ p.m. _____ 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 14, 1962</u> to <u>Jan 17, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Jan 17, 1962</u> and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L W Martin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1-17-62</u>				22c. PHYSICIAN'S NAME (Type) <u>L W Martin MD</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 18 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Conroy S. Yarns</u>			
23d. LOCATION (City, town or county) <u>Baldensburg,</u>		(State) <u>Md</u>					



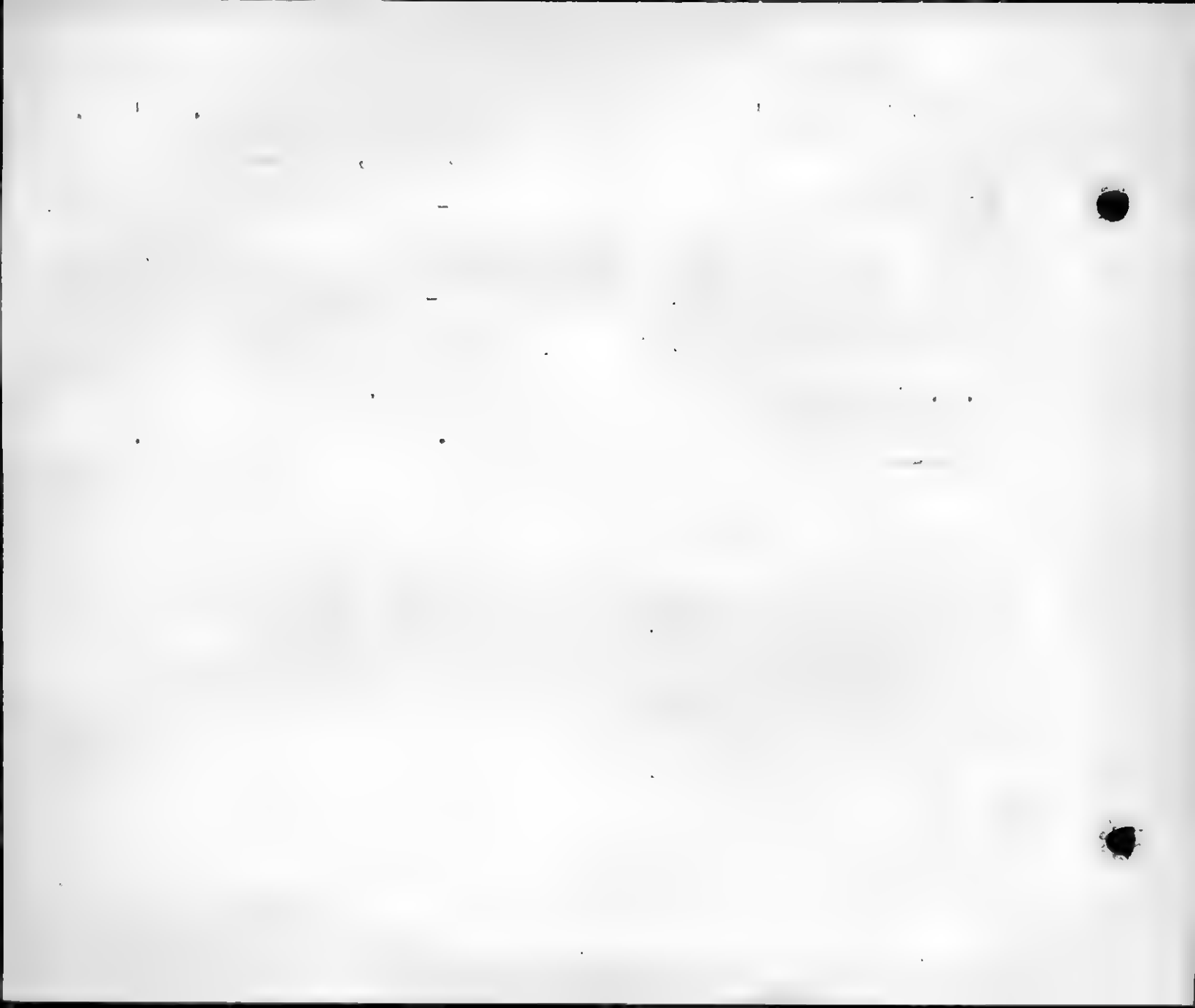
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01051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01042

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suitland Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland	
f. STREET ADDRESS 7409 - Taylor Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First INA Middle LEE Last MEREDITH		4. DATE OF DEATH Month Jan Day 26 Year 1962	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 14 - 1887
9 AGE (In years last birthday) 74 yrs		10 IF UNDER 1 YEAR Months 1 Days 26 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME L. A. Rice		14. MOTHER'S MAIDEN NAME Catherine M. Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Same as # 2.	
17. INFORMANT Zenith M. Mitchell		Address Same as # 2.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197.4 DUE TO Metastatic Pharyngeal Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7158	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Carcinoma		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10/19/55 to 1-26-1962 that (I) (we) last saw the deceased alive on 1-19-1962 and that death occurred at 3P M, from the causes and on the date stated above.			
22a SIGNATURE Thomas F. Cullen		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen, MD		22d. ADDRESS 4400 Bowen Rd. S.E. DC. 19	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Jan 29-62	
23c NAME OF CEMETERY OR CREMATORY Pedar Hill		23d LOCATION (City, town, or county) (State) Suitland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		25a. REC'D BY REGISTRAR DATE JAN 30 '62	
ADDRESS 1661-gd Hope Rd SE		25b REGISTRAR'S SIGNATURE Arthur R. Jones	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01052 01043

1. PLACE OF DEATH
a. COUNTY Prince Georges
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chaverly
c. LENGTH OF STAY IN 1b 14 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant
d. STREET ADDRESS 6410 Greigg Street

3. NAME OF DECEASED (Type or print) Baby Girl Miller
First Middle Last

4. DATE OF DEATH Jan 21 19 62
Month Day Year

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 20 Jan 1962
9. AGE (In years last birthday) yrs. 7 1/2
IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Earle Miller, Jr.
14. MOTHER'S MAIDEN NAME Merle Brickey
Address Mother Same as above

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature
DUE TO (b) Premature labor
DUE TO (c) Bleeding on Partial Placenta Previa
INTERVAL BETWEEN ONSET AND DEATH 10 h

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

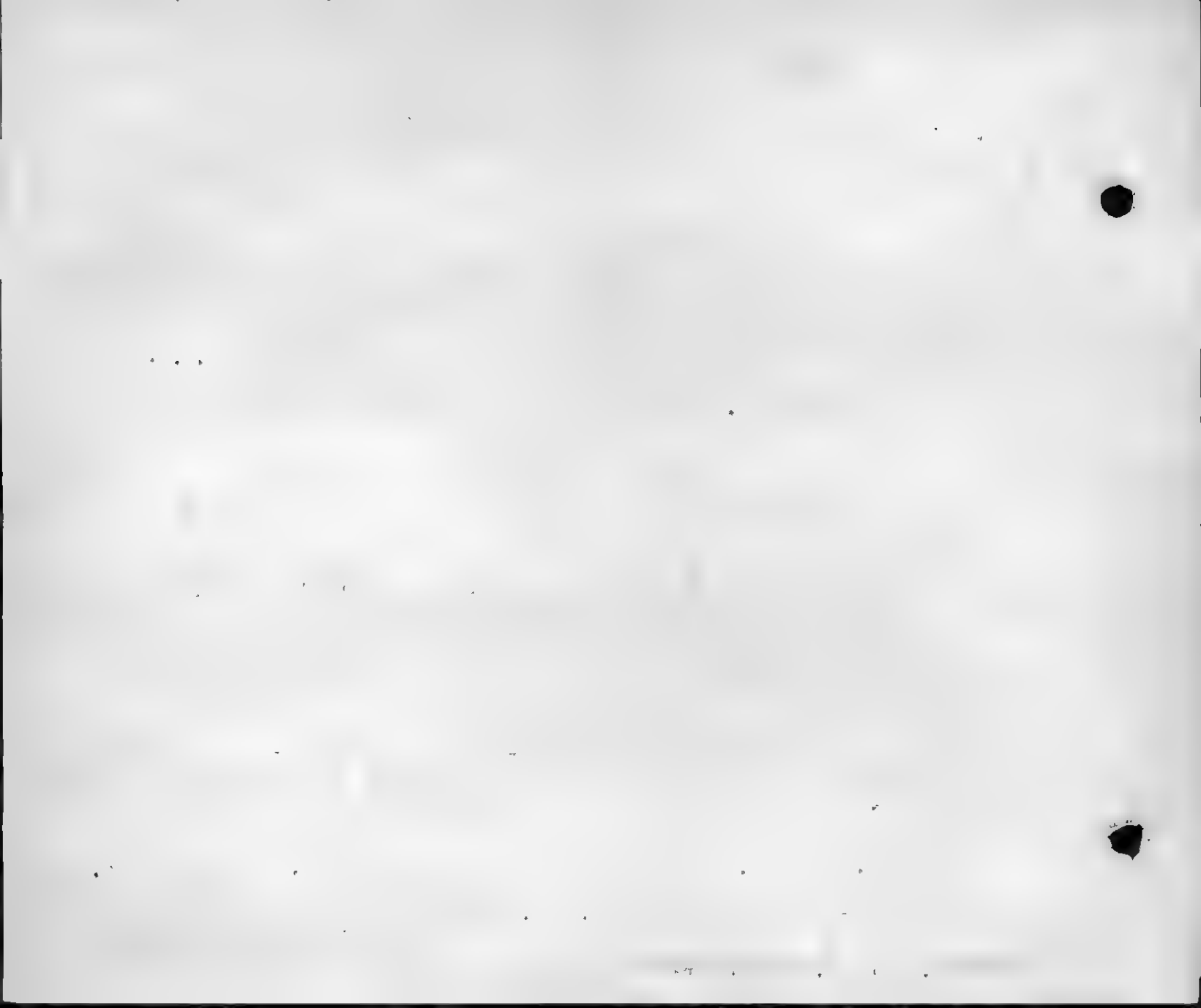
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19
Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-20 1962, to 1-21 1962, that (I) (we) last saw the deceased alive on 1-21 1962, and that death occurred at 1:10 AM from the causes and on the date stated above.

22a. SIGNATURE Carlos C. Sera
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Carlos C. Sera
22d. ADDRESS 6110 - 43rd Avenue, Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE THEREOF 2-2-62
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital
23d. LOCATION (City, town or county) Cheverly, Maryland (State)

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
25a. REC'D BY REGISTRAR DATE FEB 6 '62
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna



01053

01041

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES * MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE KENTUCKY b. COUNTY PERRY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAZARD 55X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US AIR FORCE HOSPITAL		d. STREET ADDRESS HIGHLAND AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BILLY JOE MILLER JR		4. DATE OF DEATH Month Day Year JANUARY 10 1962	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 OCTOBER 1960
9. AGE (In years lost birthday) 1		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) KENTUCKY
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME BILLY JOE MILLER SR	
14. MOTHER'S MAIDEN NAME LILLIAN BROWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO NONE		17. INFORMANT Address MOTHER (MRS LILLIAN MILLER) SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO Leukemia, lymphogenous, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ÷ month DUE TO (c) ÷ month			INTERVAL BETWEEN ONSET AND DEATH ÷ month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 JAN 1961 to 10 JAN 1962 that (I) (we) last saw the deceased alive on 10 JAN 1962 and that death occurred at 1036 AM, from the causes and on the date stated above			
22a. SIGNATURE Sanford H. Anzel		22b. DATE SIGNED 10 JAN 62	
22c. PHYSICIAN'S NAME (Type) SANFORD H. ANZEL, Capt USAF MC		22d. ADDRESS USAF Hq Wiesbaden GERMANY	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 13 JANUARY 1962	23c. NAME OF CEMETERY OR CREMATORY HAZARD KENTUCKY	
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME INC. 7400 GEORGIA NW		25a. REC'D BY REGISTRAR DATE JAN 15 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

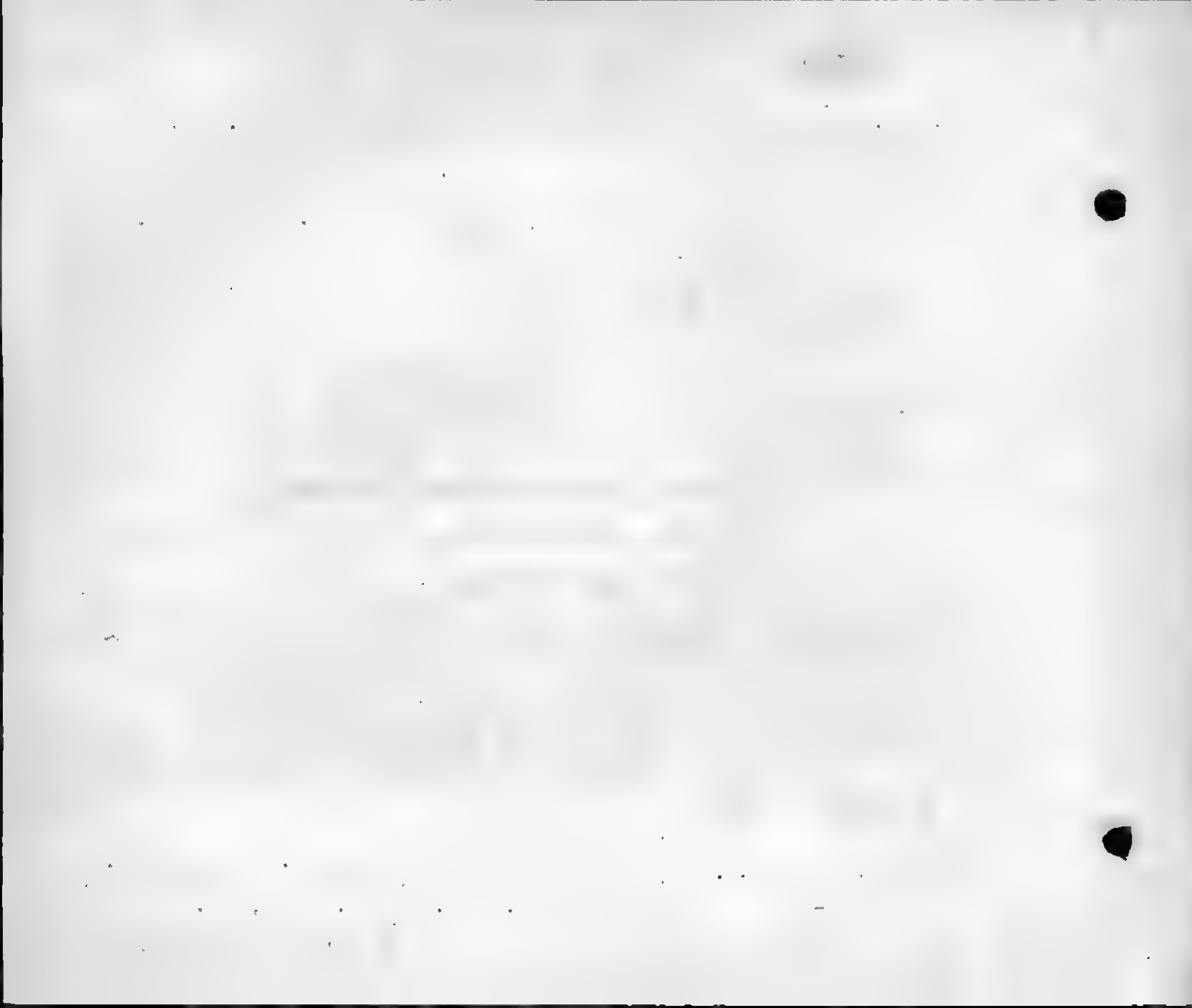
01054

CERTIFICATE OF DEATH

01045

Item 9 Film G305 1/11/62 iwr

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo. County</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN Hb <u>7 days</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Pr. Geo. County</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		d. STREET ADDRESS <u>4408 Queensbury Rd. Riverdale Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William J. Miller</u>		First		Middle		Last		4. DATE OF DEATH <u>January 3 1962</u>		Month		Day		Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-99</u>		9. AGE (In years last birthday) <u>62 6/1</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>									
13. FATHER'S NAME <u>John C. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Minnier Sprosser</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>															
331X DUE TO (b) <u>Arteriosclerosis</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension.</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Diabetes Mellitus</u>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12-31</u> , 19 <u>61</u> , to <u>1-3-62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-3-1</u> , 19 <u>62</u> , and that death occurred at <u>1:58</u> M., from the causes and on the date stated above.															
22a. SIGNATURE <u>D. R. Purdie</u>						M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Donald R. Purdie M.D.</u>						22d. ADDRESS <u>4408 Queensbury Rd. Riverdale, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-8-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>				23d. LOCATION (City, town or county) <u>Ft. Myer, Va.</u>				(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 300-H St. NE Wash. DC</u>						ADDRESS <u>Wash. DC</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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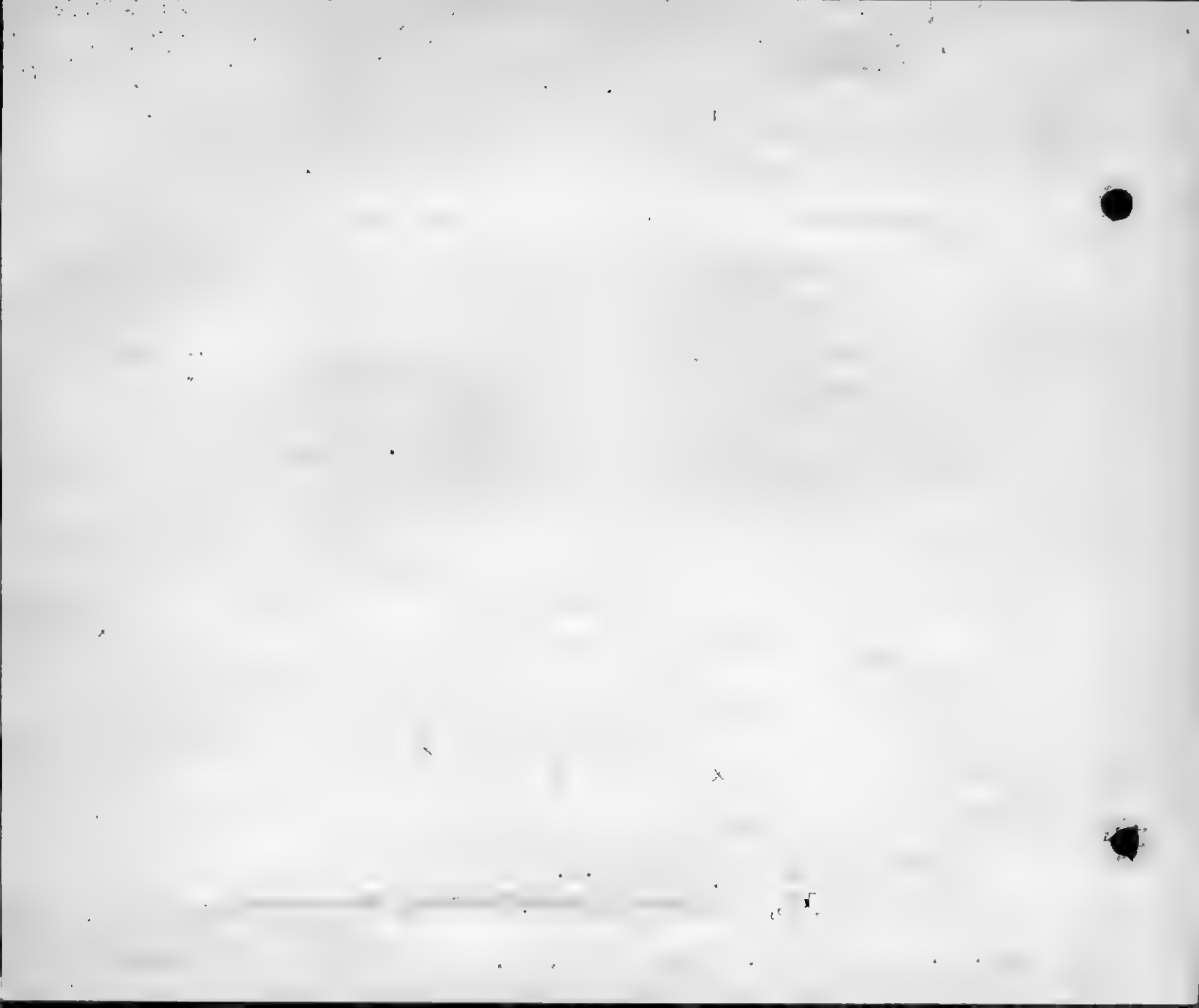
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01046

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7804 Atwood Street</u>		d. STREET ADDRESS <u>7804 Atwood Street</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Howard</u> Last <u>Mock</u>		4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1918</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Sargent</u>		9b. AGE (In years last birthday) <u>43</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Airforce</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Walter Mock</u>		14. MOTHER'S MAIDEN NAME <u>Viola Wingate</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Katherine M. Mock, same as # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS and MYOCARDITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>492X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>1/11/62</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 16, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 15 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krome</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01056

CERTIFICATE OF DEATH

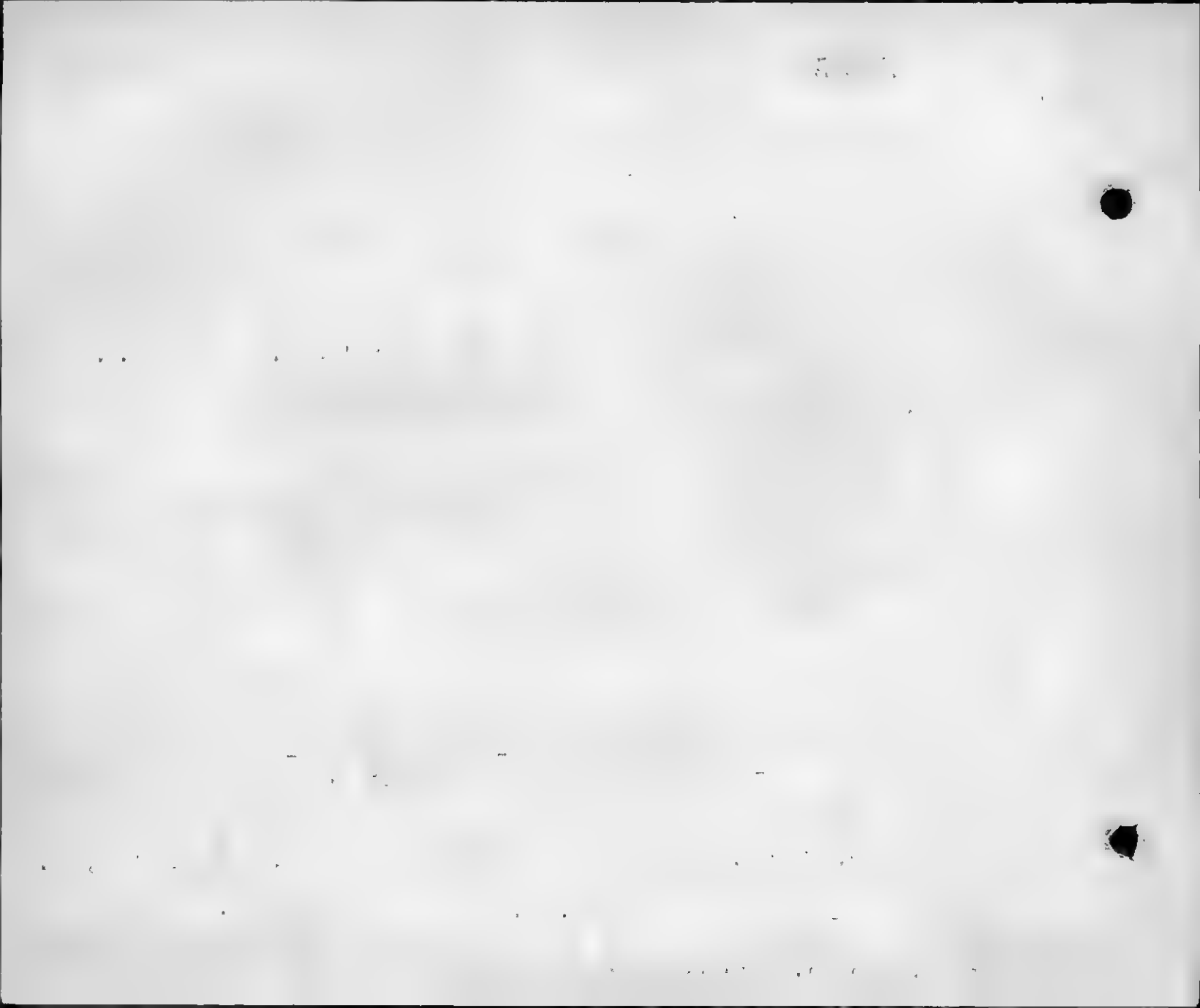
01047

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Hrs. 20 Min		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Colmar Manor	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH Month January Day 21 Year 1962		g. AGE (In years, last birthday) yrs. 2 Mns. 20		h. IF UNDER 1 YEAR Months 2 Days 20		i. IF UNDER 24 HRS. Hours 2 Mns. 20	
3. NAME OF DECEASED (Type or print) Baby		4. DATE OF DEATH Moore		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-21-62	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY		10. BIRTHPLACE (County & State or foreign country) Prince George's, Md.		11. CITIZEN OF WHAT COUNTRY U.S.A.		12. FATHER'S NAME Moore, James Joseph		13. MOTHER'S MAIDEN NAME Carol Jo Wootten		14. SOCIAL SECURITY NO. 1-21-62	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. INFORMANT Mother		17. ADDRESS Same as above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (b) 7-1-5 causing the underlying cause last. (c) 5 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-21 , 19 62 , to 1-21 , 19 62 that (I) (we) last saw the deceased alive on 1-21 , 19 62 , and that death occurred at 3:50 PM on the causes and on the date stated above.		22a. SIGNATURE Dr. Milos A. Jansa		22b. DATE SIGNED 1-21-62		22c. PHYSICIAN'S NAME (Type) Dr. Milos A. Jansa		22d. ADDRESS 7403 Varbum Street, Landover Hills, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Cremation 12-2-62		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.		25a. REC'D BY REGISTRAR DATE FEB 6 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01057

01045

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHINTON</u> c. LENGTH OF STAY IN 1b <u>2 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southern Maryland Medical Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHINTON</u> d. STREET ADDRESS <u>Rt 1 Box 240</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAUDE C</u>	4. DATE OF DEATH <u>MORAN</u> <u>JAN. 29</u> 19 <u>62</u>	5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>JULY 17-1888</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BRANDYWINE, MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John W. Young</u> 14. MOTHER'S M maiden NAME <u>Mary Ann Truemon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give number of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>(SON)</u> <u>SINCLAIR MORAN</u> Address <u>Rt 1 Box 240 CHINTON, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Cerebrovascular Accident (Hemorrhage) death 4 days</u> (b) <u>Hypertensive Arteriosclerotic Cardio-vascular disease</u> (c) <u>20+ years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20c. TIME OF INJURY Month, Day, Year <u>None</u> 20d. INJURY OCCURRED <u>None</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Jan. 29, 1962</u> to <u>Jan. 29, 1962</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>Jan. 29, 1962</u> and that death occurred at <u>10:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D. 22b. DATE SIGNED <u>1/29/62</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D.</u> 22d. ADDRESS <u>BRANCH AVE. CHINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-1-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Clinton Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>10661 - Road Hope Rd SE WASH. 20 00</u> 25a. READ BY REGISTRAR <u>DAJAN 31 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Health Department for instructions. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01049

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brentwood	
c. LENGTH OF STAY IN b. D.O.A.		d. STREET ADDRESS 3410 Windom Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ann Mae Morrison	4. DATE OF DEATH January 15, 1962	5. SEX Female 6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1915	9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Richards Matthews Miller	14. MOTHER'S MAIDEN NAME Mattie Eanes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 578-14-4757	17. INFORMANT Malcolm William Morrison Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxia 891.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute carbon monoxide poisoning DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Was in a building subjected to motor exhausts	
20c. TIME OF INJURY Month, Day, Year 6:00 AM 1/15/62	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Brentwood (County) P. G. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE JAMES I. BOYD, M.D.		DATE SIGNED 1/15/62	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county) Colmar Manor, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 18, 1962	22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	22d. LOCATION (City, town, or country) (State)
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REG. STRAR JAN 18 '62	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

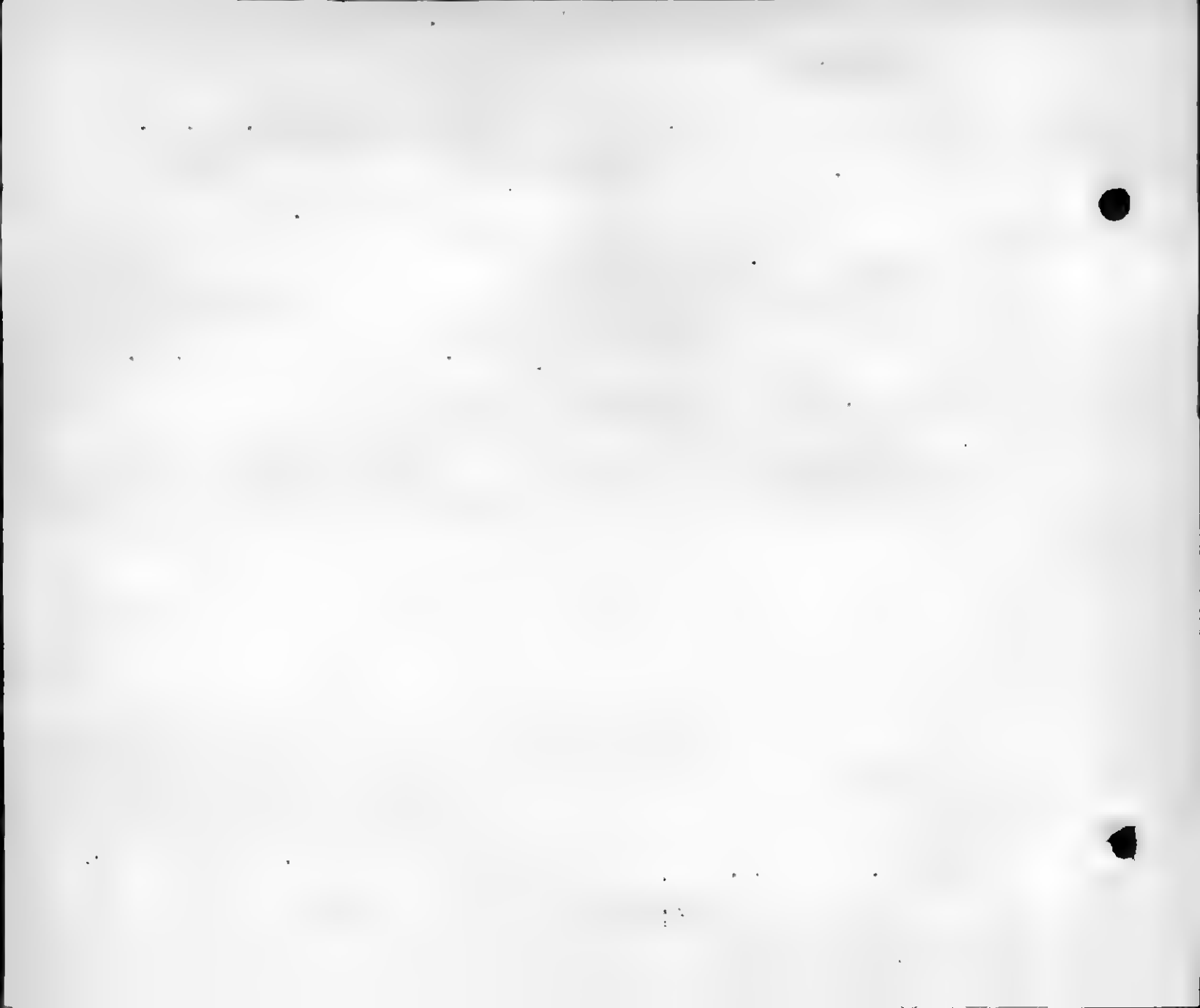
0001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
01059													
01050													
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u> c. LENGTH OF STAY IN 1b <u>16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5101 Crittenden St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Harold I. Ira</u> First Middle Last <u>Moses</u>						4. DATE OF DEATH Month Day Year <u>1 4 19 62</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-21-11</u>		9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days <u>19 62</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. Moses</u>						14. MOTHER'S MAIDEN NAME <u>Catherine Ann Rich</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war/dates of service) <u>Unk.</u>						16. SOCIAL SECURITY NO. <u>Unk.</u>						17. INFORMANT <u>Hospital Records as above</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4 20 00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic heart disease</u> (c) _____												INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>12-19</u> , 19 <u>61</u> to <u>1-4</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> , 19 <u>62</u> , and that death occurred at <u>12:25</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>D.R. Purdie</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Donald R. Purdie M.D.</u>						22d. ADDRESS <u>4408 Queensbury Rd. Riverdale, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 8, 1962</u>		23c. NAME OF CEMETERY <u>Prospect Cemetery</u>				23d. LOCATION (City, town or county) _____ (State) _____ <u>Stroudsburg, Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Funeral Home Hyattsville Md.</u>						ADDRESS <u>Hyattsville Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>			

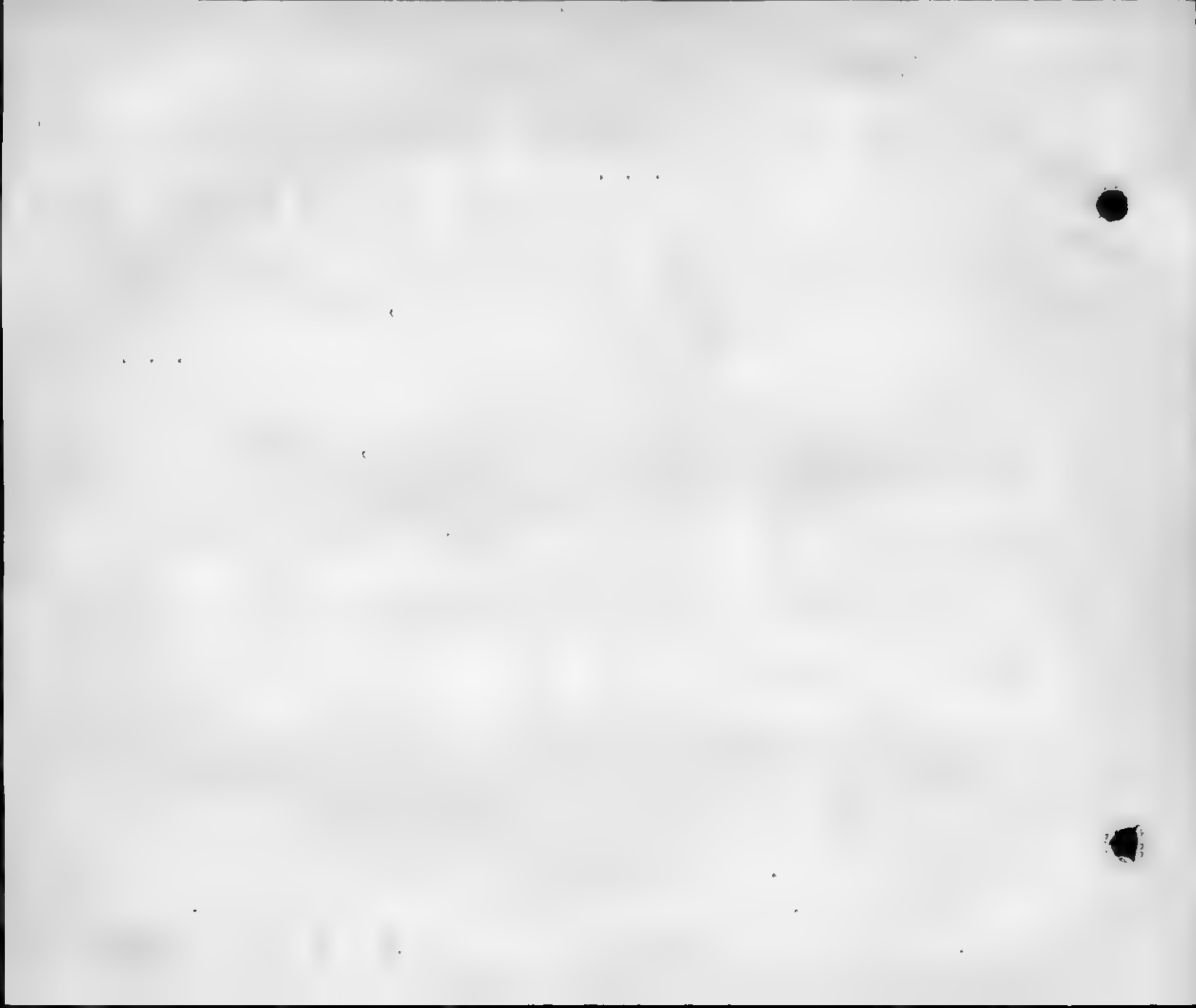


214
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

214
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01060 MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01051

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 63 Hatfieldville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4508 Buchanan Street	
3. NAME OF DECEASED (Type or print) Raymond Cassius Myers		4. DATE OF DEATH January 6 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1894 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Virginia	
10b. KIND OF BUSINESS OR INDUSTRY Retired		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Clinton Myers		14. MOTHER'S MAIDEN NAME Annie Goodhart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Matilda Myers, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease (c) Coronary artery disease DUE TO cause listed.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type)		DATE SIGNED January 6, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 8, 1962	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville Md		24a. REC'D BY REGISTRAR JAN 9 '62 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

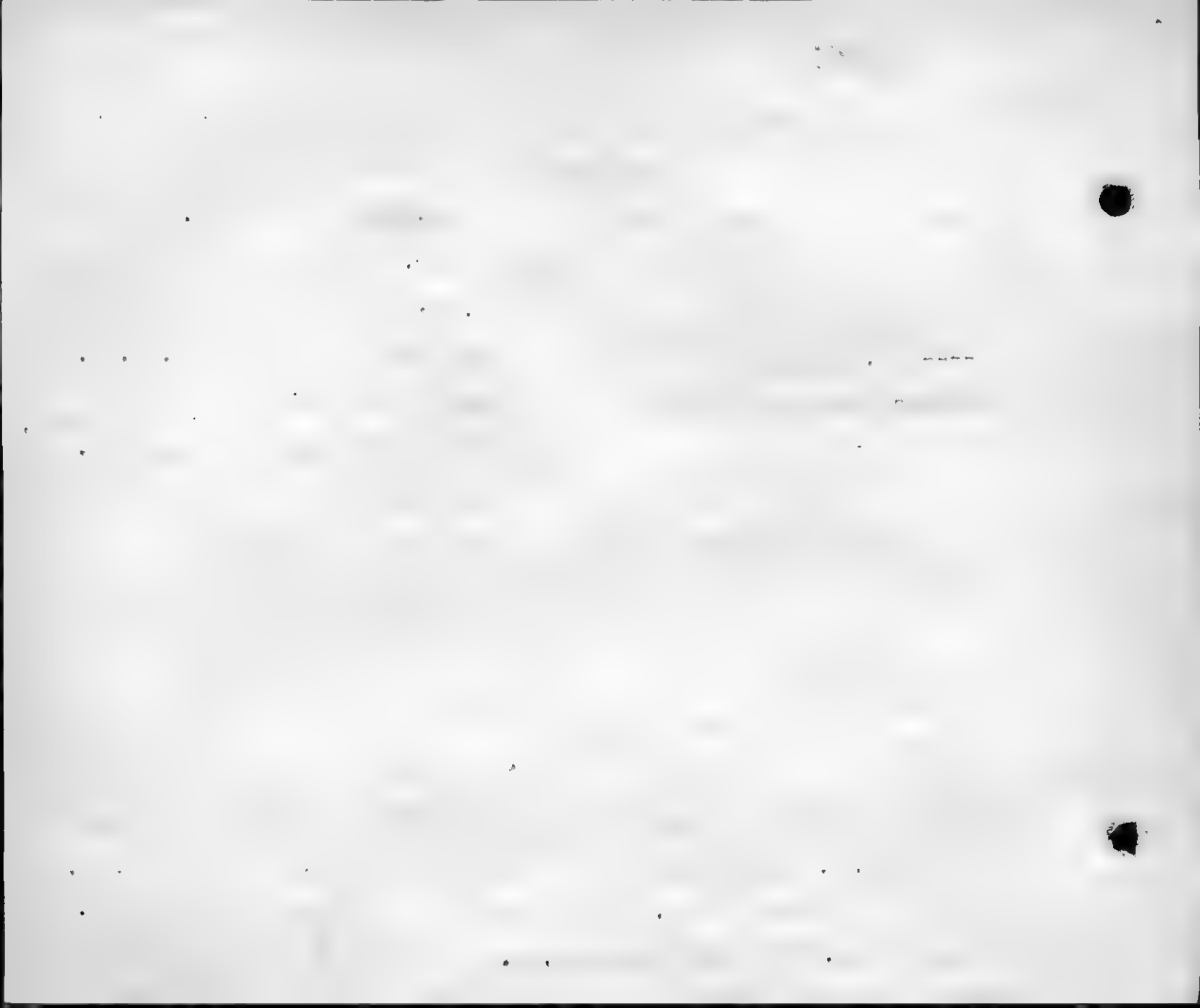
01061

01052

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>2001 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u> d. STREET ADDRESS <u>xxxxxx Central Ave.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter</u> <u>Thomas</u> <u>Nicholson Sr.</u>		4. DATE OF DEATH Jan 16 1962		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1873</u>			
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farmer & General Merchandise</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Store & Farm</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Nicholas Reverdy Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Maria Tydings</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mary Elizabeth Nicholson-</u>				Address <u>Mitchellville, Maryland.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> DUE TO (b) <u>Surgical Cecostomy</u> DUE TO (c) <u>Intestinal Obstruction due to Sigmoid Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pleural effusion</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/13, 1962, to 1/15, 1962 that (I) (we) last saw the deceased alive on 1/15, 1962, and that death occurred 6, 25 AM from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. A. Clark Holmes</u>				22b. DATE SIGNED <u>1/16/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Clark Holmes</u>				22d. ADDRESS <u>4108 Pratt Street, Upper Marlboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/18/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Oak Cemetery</u>			
23d. LOCATION (City, town or county) <u>Mitchellville, Md.</u>		23e. REC'D BY REGISTRAR DATE <u>JAN 25 '62</u>		23f. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home - Upper Marlboro, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



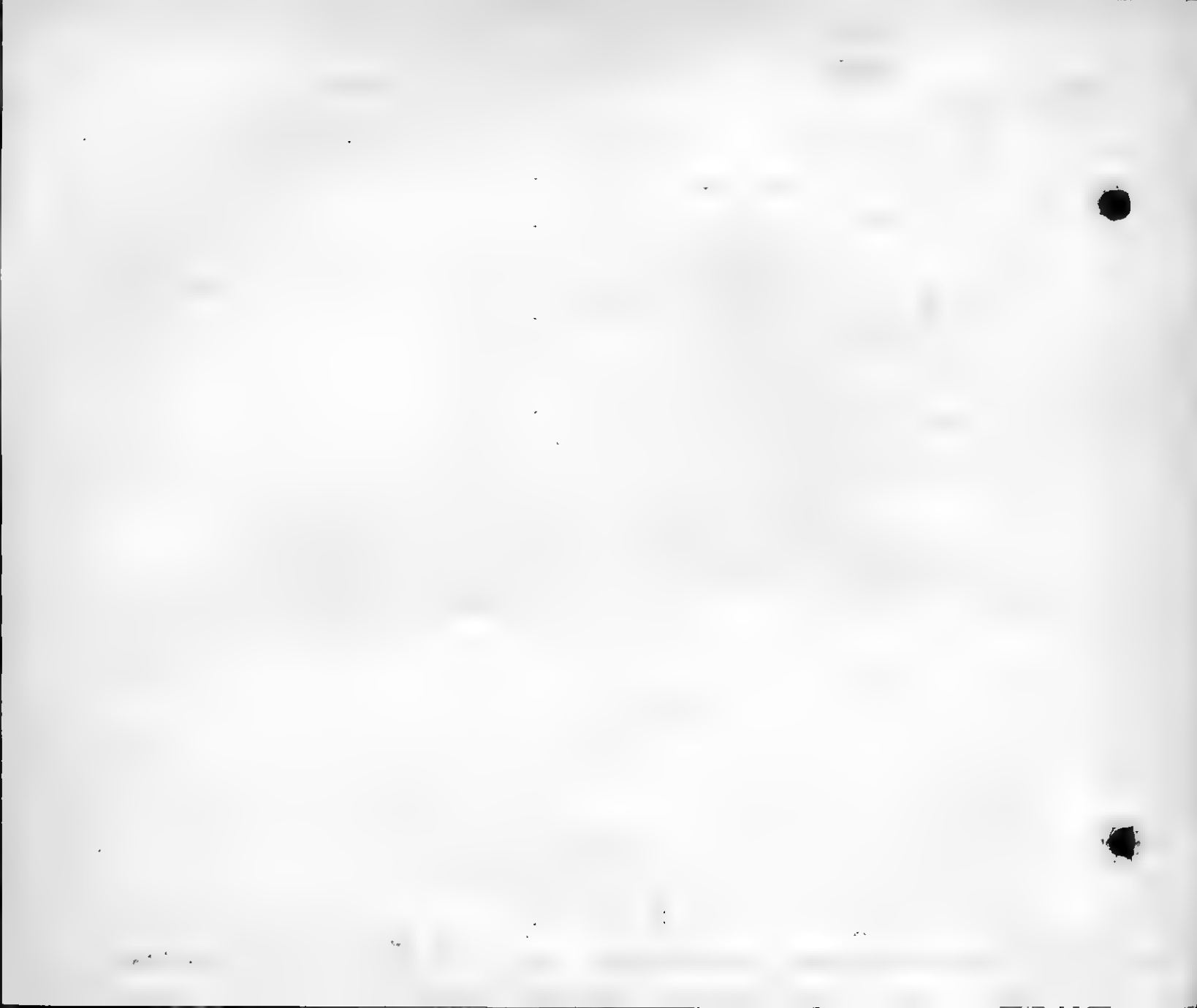
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01062

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN TB <u>14 days</u>		d. STREET ADDRESS <u>4802 48th Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Ouellette</u> Last <u>Ouellette</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ma.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Uncle</u>		14. MOTHER'S MAIDEN NAME <u>Uncle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Record Office</u>	
17. INFORMANT <u>Record Office</u>		Address <u>4408 Queensbury Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420 DUE TO (b) <u>420</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>420</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVA. BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-28-</u> <u>1961</u> to <u>1-7-</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>1-6-</u> <u>1962</u> and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles House</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Pasche Sons</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01063

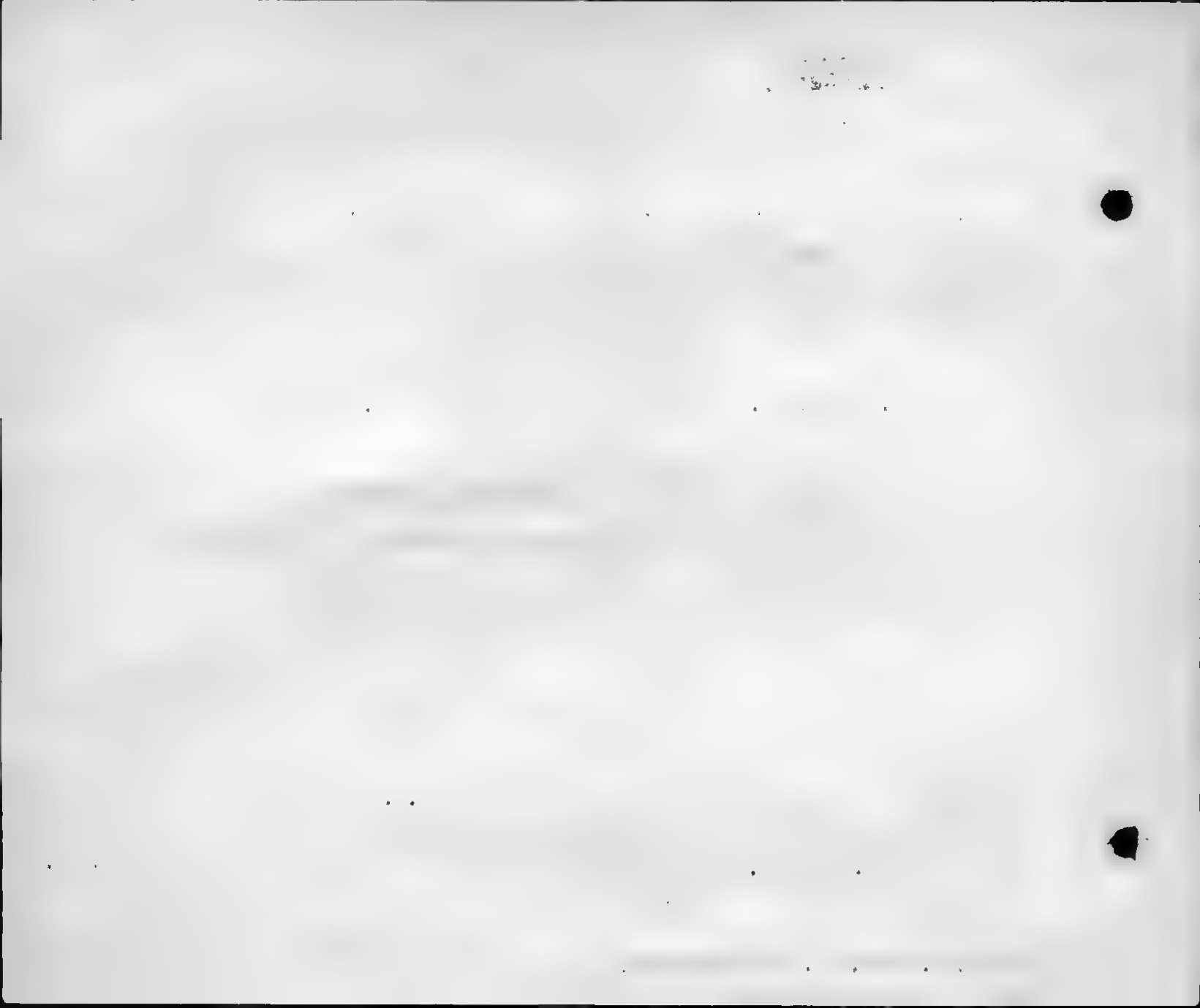
CERTIFICATE OF DEATH

01054

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6600 Greig Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Owens		4. DATE OF DEATH January 8 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John F. Owens, Sr.		14. MOTHER'S MAIDEN NAME Patricia Marie Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mother	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7545 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Pul Abetected as is Myocardial Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/6/ 19 62 to 1/8 1962 , that (I) (we) last saw the deceased alive on 1/8 1962 , and that death occurred 4:30A , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Milos A. Jansa 22c. PHYSICIAN'S NAME (Type) Dr. Milos A. Jansa		22b. DATE SIGNED A.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 7403 Varnum Street, Landover Hills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 1/22/62	23c. NAME OF CEMETERY OR CREMATORY Prince George's General	23d. LOCATION (City, town or county) (State) Cheverly, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Pann, Jr., Administrator		25a. REC'D BY REGISTRAR JAN 24 '62 25b. REGISTRAR'S SIGNATURE Charles L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

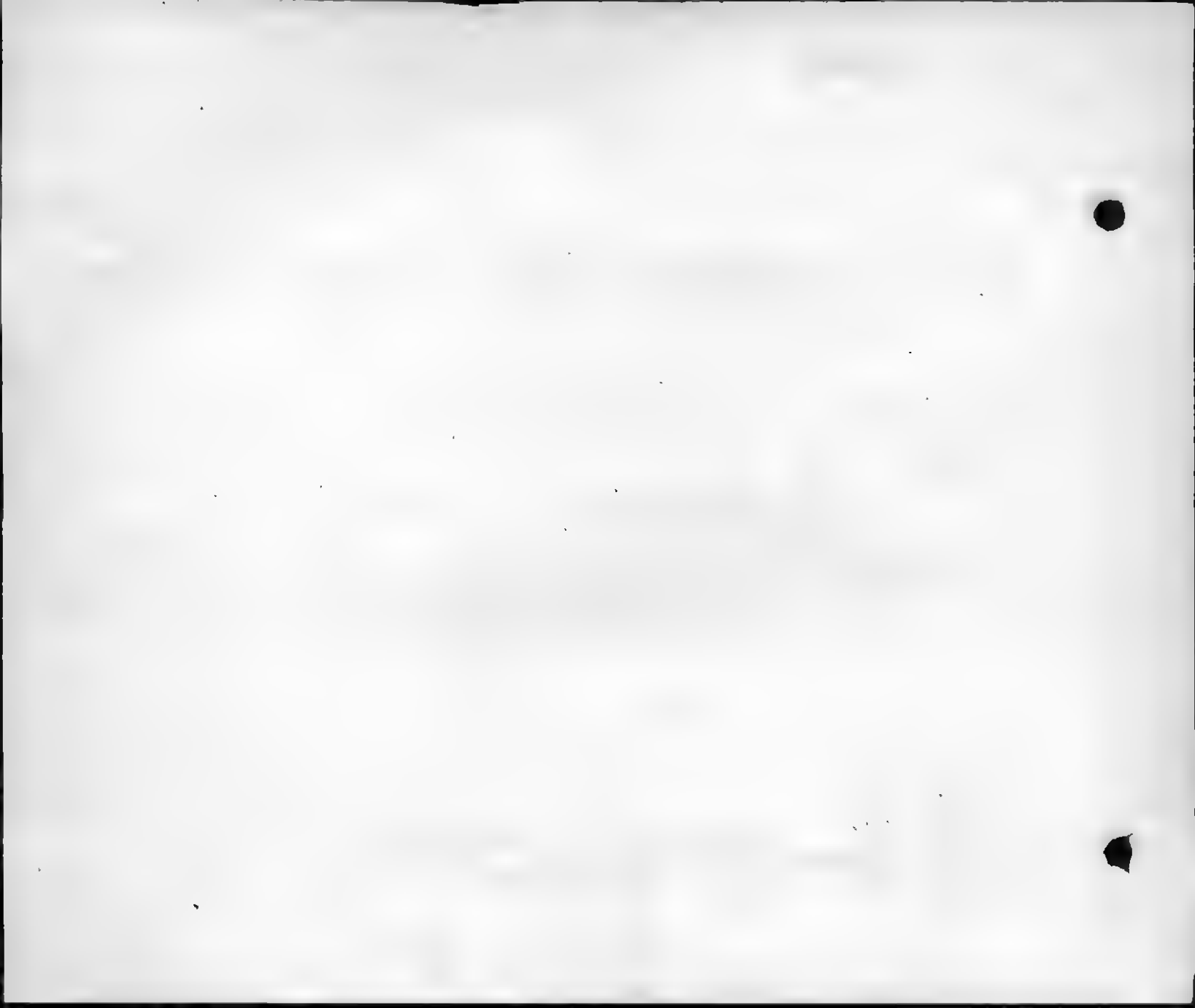
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE-1, MARYLAND

CERTIFICATE OF DEATH

01064

01055

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> c. LENGTH OF STAY IN 1b <u>4 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6513 Parkway Court</u>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 W. Hyattsville, Md</u> d. STREET ADDRESS <u>16513 PARKWAY CT.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEOCARDIA</u> Middle <u>G</u> Last <u>PALMER</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 4, 1874</u>
9. AGE (in years last birthday) <u>89</u> yrs		10. UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.	11. UNDER 24 HRS Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred C. Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Louise Toomey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HATTIE L Howard</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive and arteriosclerotic Cardiovascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>20 Nov 1961</u> to <u>1 Jan 1962</u> that (I) (we) last saw the deceased alive on <u>1 Jan 1962</u> and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Thomas P Fogarty</u> M.D.		22b. ADDRESS <u>1011 UNIV. BLVD E. SILVER SPRING MD</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS P FOGARTY</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 3, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>—</u>		23d. LOCATION (City, town, or county) (State) <u>Poughkeepsie N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Taltonell</u> ADDRESS <u>3603 14th St NW DC 10</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		25c. REGISTRAR'S SIGNATURE <u>—</u>	



2 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

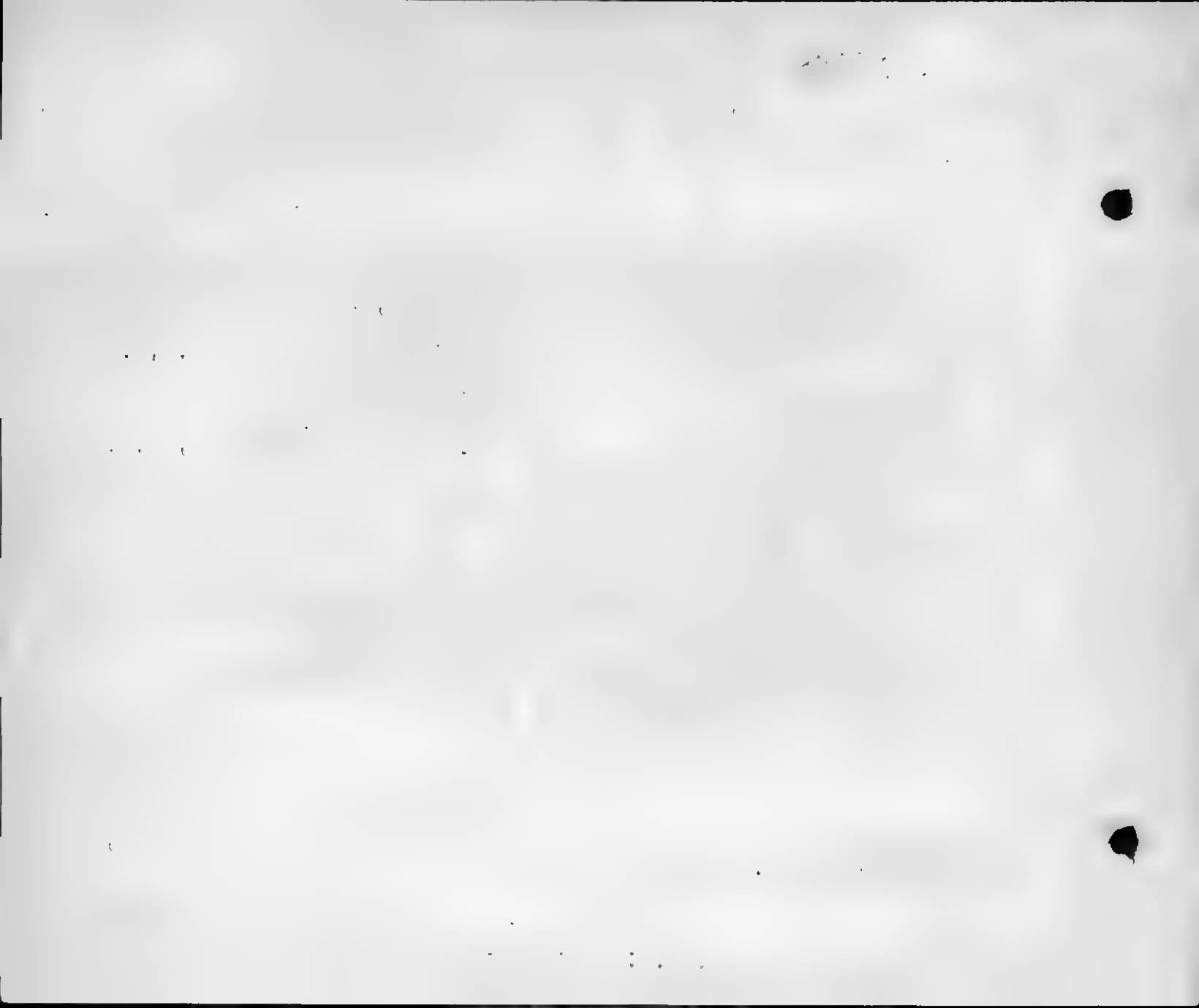
X

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01056

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights				c. LENGTH OF STAY IN 1b 36 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 716 58th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sophonria Sanford				4. DATE OF DEATH Month January Day 21 Year 19 62			
5. SEX Female				6. COLOR OR RACE Colored			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH November 18, 83			
9. AGE (In years last birthday) 78 yrs.				10. IF UNDER 1 YEAR Months 78 Days 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Oscar Sanford				14. MOTHER'S MAIDEN NAME Aleinda Fox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT John S. Palmer				18. ADDRESS 2414 Lawrence Street NE Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 4 + 2 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
DATE SIGNED January 21, 1962							
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 1/24/62		22c. NAME OF CEMETERY OR CREMATORY West View		22d. LOCATION (City, town, or country) (State) Upperville, Virginia			
23. FUNERAL DIRECTOR Brooks & Allen							
ADDRESS 1200 Fla. Ave. N.W. Washington, D.C.							
24a. REC'D BY REGISTRAR 1/23/62							
24b. REGISTRAR'S SIGNATURE Clifford L. Krause							



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

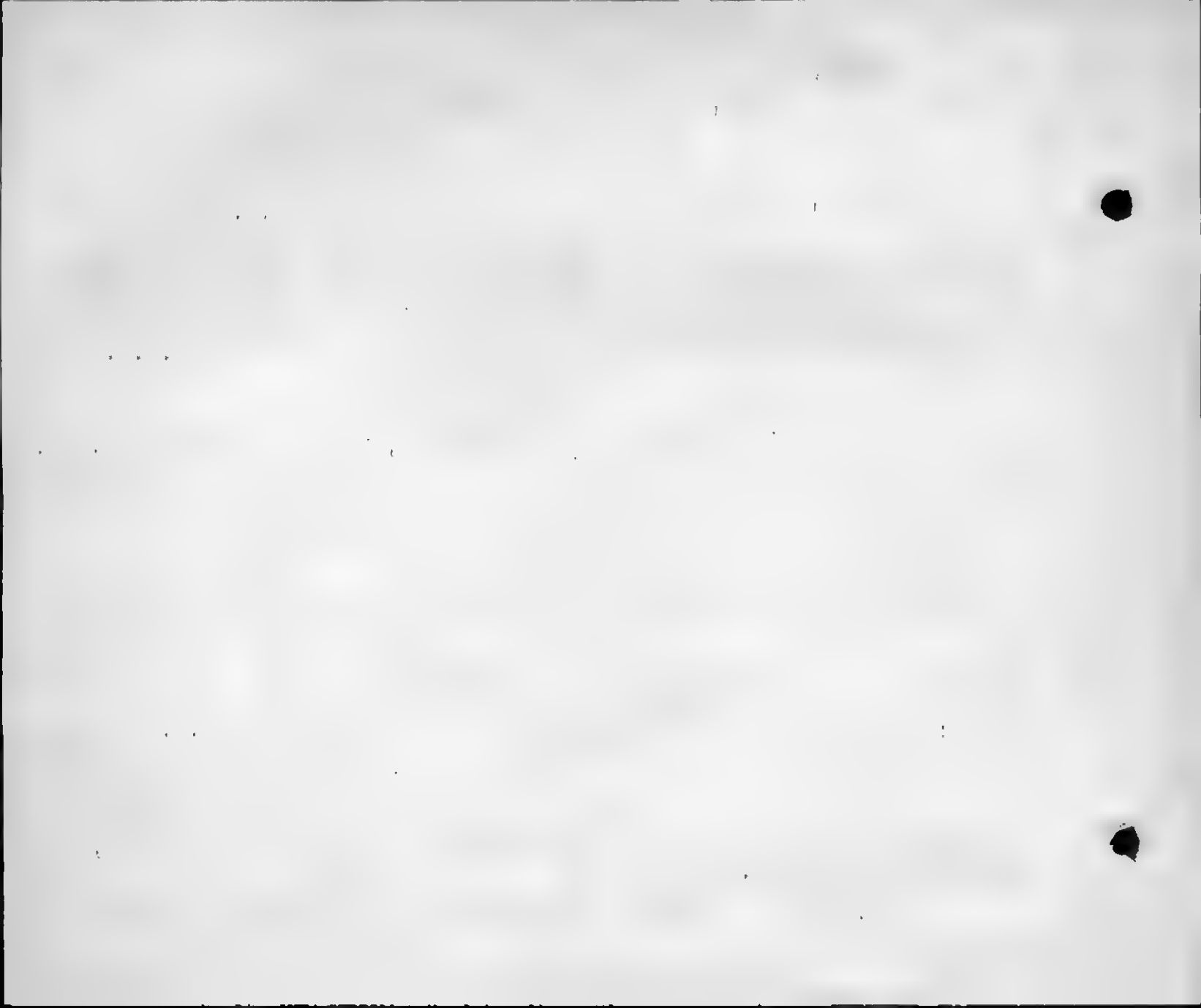
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01057

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. at on: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY in lb 3 hours		d. STREET ADDRESS 574 49th Place N.W. N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daniel Payton		4. DATE OF DEATH January 21 1962	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 30, 1940	
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Daniel Robinson		14. MOTHER'S MAIDEN NAME Ruth Payton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-52-6934	
17. INFORMANT John Bailly, 1358 Upper Marlboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause, or line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 781X HEMORRHAGE AND SHOCK DUE TO Condit ions, if any, which gave rise to immediate cause (b) CONSTRICT WOUND OF ABDOMEN (c) DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 2			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during an altercation			
20c. TIME OF INJURY Month, Day Year 10:45 1/20/62			
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dance hall			
20f. (City or town) Deanwood P.G. (County) Md			
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town or county)			
DATE SIGNED January 21, 1962			
22a. DATE OF REMOVAL (Specify) 1-27-62			
22b. NAME OF CEMETERY OR CREMATORY Nat Harmony			
22c. LOCATION (City, town, or country) Highland Pk Md			
23. FUNERAL DIRECTOR Henry Washington 4425 Dean Ave NE			
24a. REC'D BY REGISTRAR 29 '62			
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the delay in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

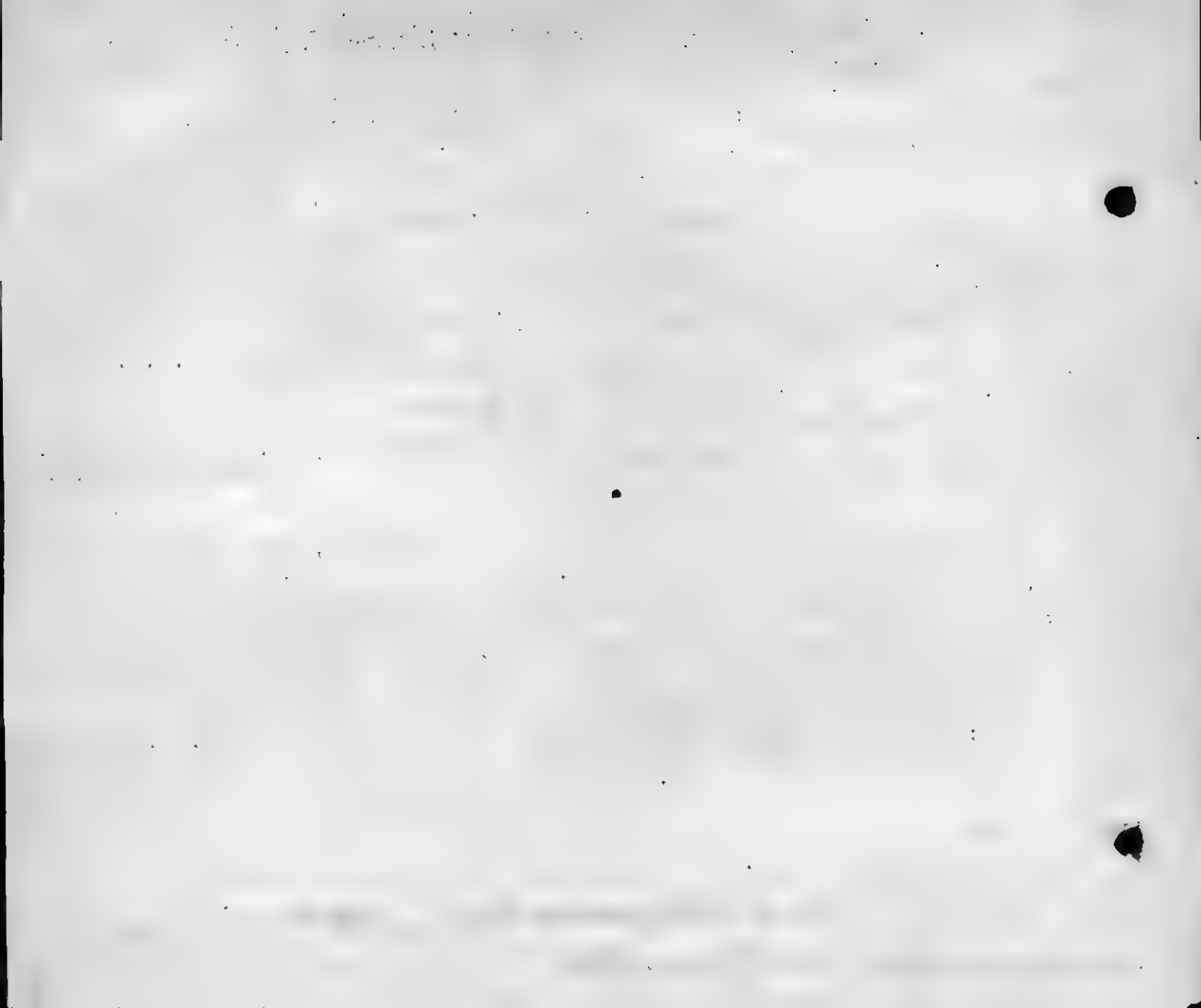


FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01067		Item 2 File G-905		1/29/62 iwk		41058			
1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Choverly							
c. LENGTH OF STAY IN It		8 hrs							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince George's General Hospital							
3. NAME OF DECEASED (Type or print)		Ralph Peterson							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		156 yrs.		January 3 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None				Virgin Islands		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Unknown		Unknown		No		None		Hospital Records, St. Elizabeth's Hos.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERNAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Shock							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DU TO Intracranial Hemorrhage, compound fractures of both legs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile							
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
7:47 p.m. 1/21/1962		et work <input checked="" type="checkbox"/>		Road		Suitland B. G. Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)	
BURIAL		1-9-62		ST. ELIZABETHS HOSP.		WASH. D.C.			
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
W. F. EDWARDS, ST. ELIZ. HOSP.		JAN 8 '62		C. L. Thomas					

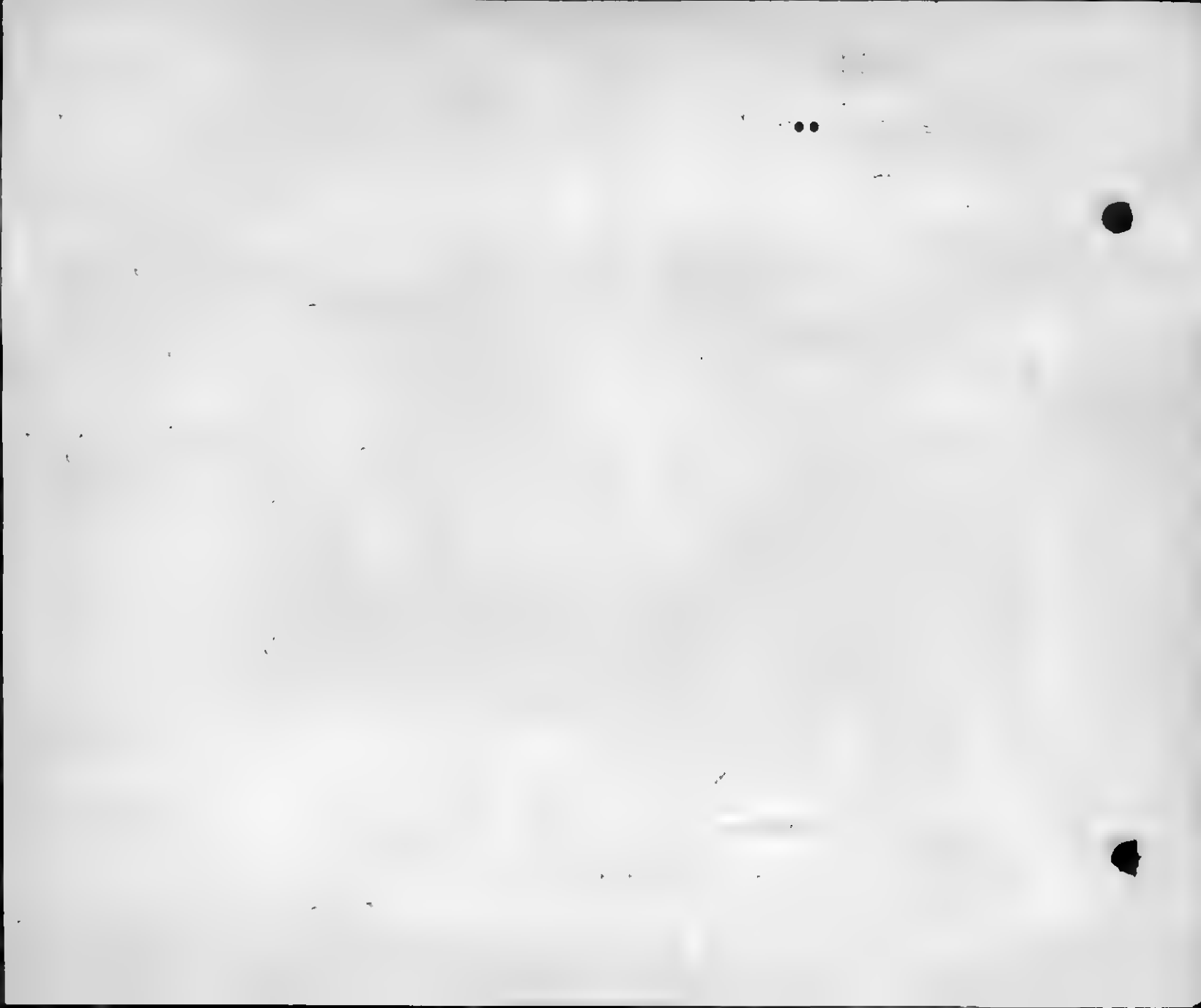


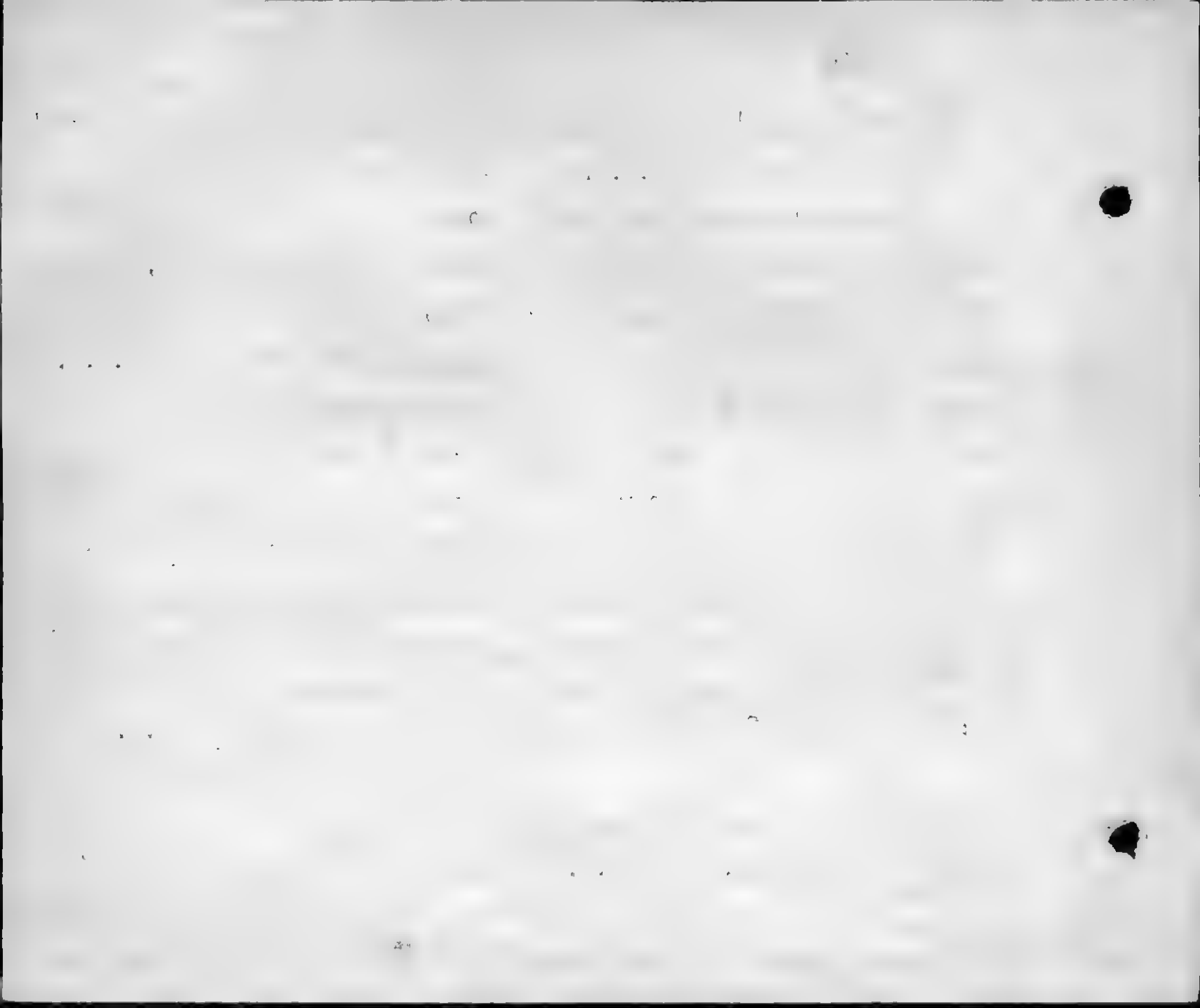
1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01059

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4909 Quincy Street</u>		e. STREET ADDRESS <u>4909 Quincy Street</u>	
3. NAME OF DECEASED (Type or print) <u>Charles E Petty</u>	4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1962</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>February 6, 1887</u> 9. AGE (In years last birthday) <u>74</u> yrs. <u>10</u> months <u>10</u> days <u>10</u> hours <u>10</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Egg Candler</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Packing Company</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Unknown</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Unknown</u> Address <u>Bladensburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>615X PYELONEPHRITIS and HYDRONEPHROSIS</u> DUE TO (b) <u>HYPERTROPHY OF PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>W. W. Charlebois</u>		24a. REC'D BY REG-STRAR <u>W. W. Charlebois</u>	
24b. REGISTRAR'S SIGNATURE <u>W. W. Charlebois</u>		DATE <u>JAN 18 '62</u>	





01070

CERTIFICATE OF DEATH

Reg. Dist. No. 01061

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 Tent Street				d. STREET ADDRESS 119 Tent Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leonard Middle A. Last Pipkin				4. DATE OF DEATH Month Jan Day 26 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Pipkin				14. MOTHER'S MAIDEN NAME Caroline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 579-05-4385			
17. INFORMANT Pearl M. Pipkin Same as #2 (Wife)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 1720 0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH minutes year year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from July , 19 60 , to Jan 26 , 19 62 , that I last saw the deceased alive on Jan 20 , 19 62 , and that death occurred at 4 p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James Kurtz				ADDRESS (Street, city or town, state) RFD Glenn Dale Md			
DATE SIGNED 1/26/62							
PHYSICIAN'S NAME (Type) Dr. James Kurtz							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 1/29/62		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Church		22d. LOCATION (City, town, or county) (State) Collington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE FEB 1 '62	
24b. REGISTRAR'S SIGNATURE William S. Hume							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

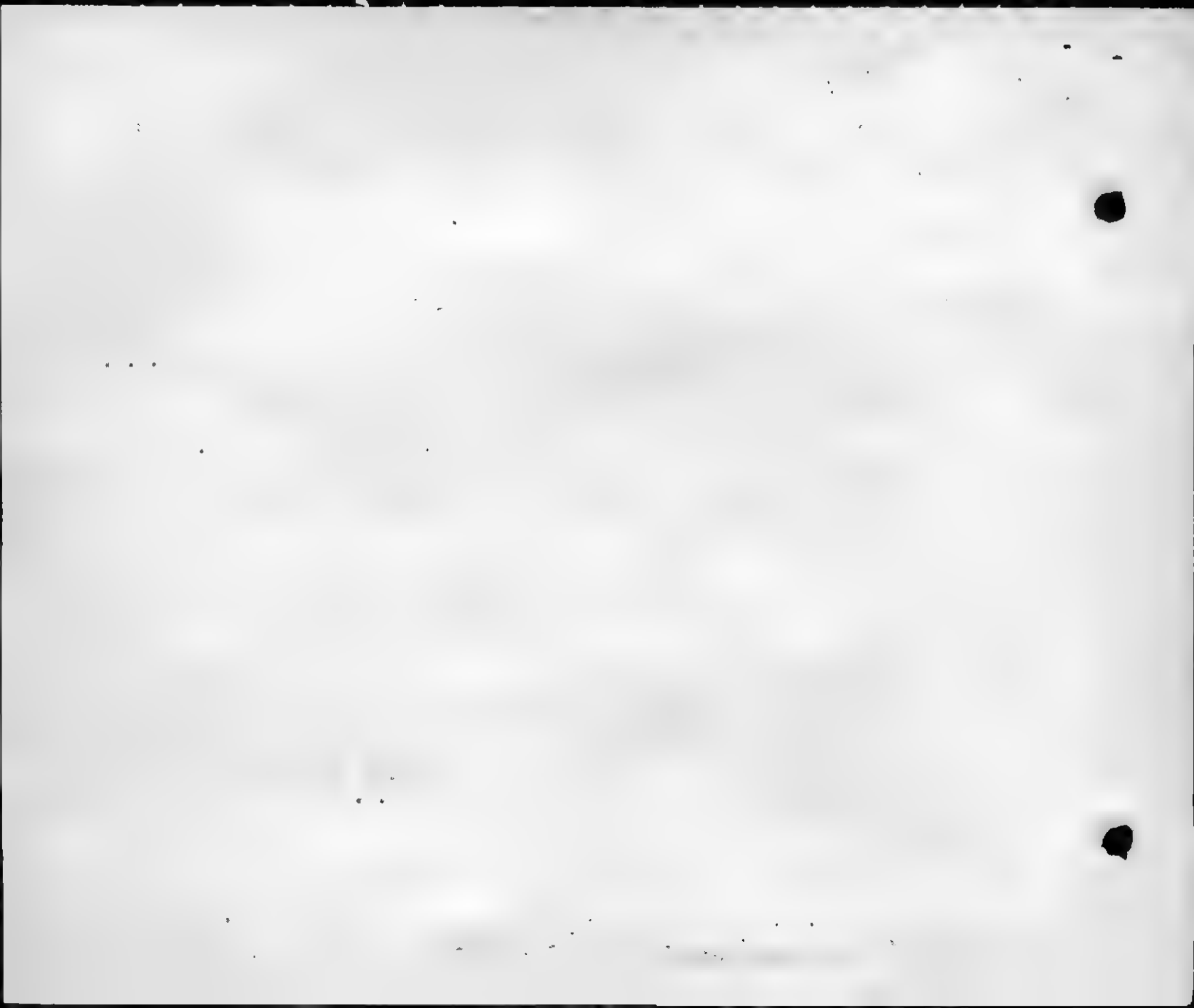
01071

01062

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>Rt. 1 Box 223</u>			
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last		4. DATE OF DEATH <u>January 4 19 62</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-07</u>	9. AGE (In years less birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leonard Pirner</u>					
14. MOTHER'S MAIDEN NAME <u>Anna Pirner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>Donald Pirner</u>		17. INFORMANT Address <u>Brandywine, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-15-57</u> , to <u>1-4-62</u> , that (I) (we) last saw the deceased alive on <u>1-3-62</u> , and that death occurred at <u>6:20</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobson</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		22d. ADDRESS <u>Brandywine, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 6, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) <u>Suitland, Md.</u>	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home, Waldorf, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 11 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Clifford S. Kraus</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the Director, Page 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Item 20d Film 307
1-14-62 ans

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01072 01063

1. PLACE OF DEATH
a. COUNTY **Prince George's County MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cheverly, DOA**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Prince George's General Hosp., 7702 Kipling Pkwy.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Pr. Geo.**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **District Hts. Md.**
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **PAUL RAYMOND PORTER**
4. DATE OF DEATH **Jan. 13th 19 62**
Month Day Year

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **July 4-1925**
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) **36** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **U.S. Marshal** 10b. KIND OF BUSINESS OR INDUSTRY **Law Enforcement** 11. BIRTHPLACE (State or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **Paul Samuel Porter** 14. MOTHER'S MAIDEN NAME **Rose Schmidt**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes World War 2** 16. SOCIAL SECURITY NO. **298-18-7333** 17. INFORMANT **Geraldine Constance Porter Same as 2** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **HEMORRHAGE AND SHOCK**
DUE TO **LACERATION OF AORTA AND SPINAL CORD**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **823X**
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

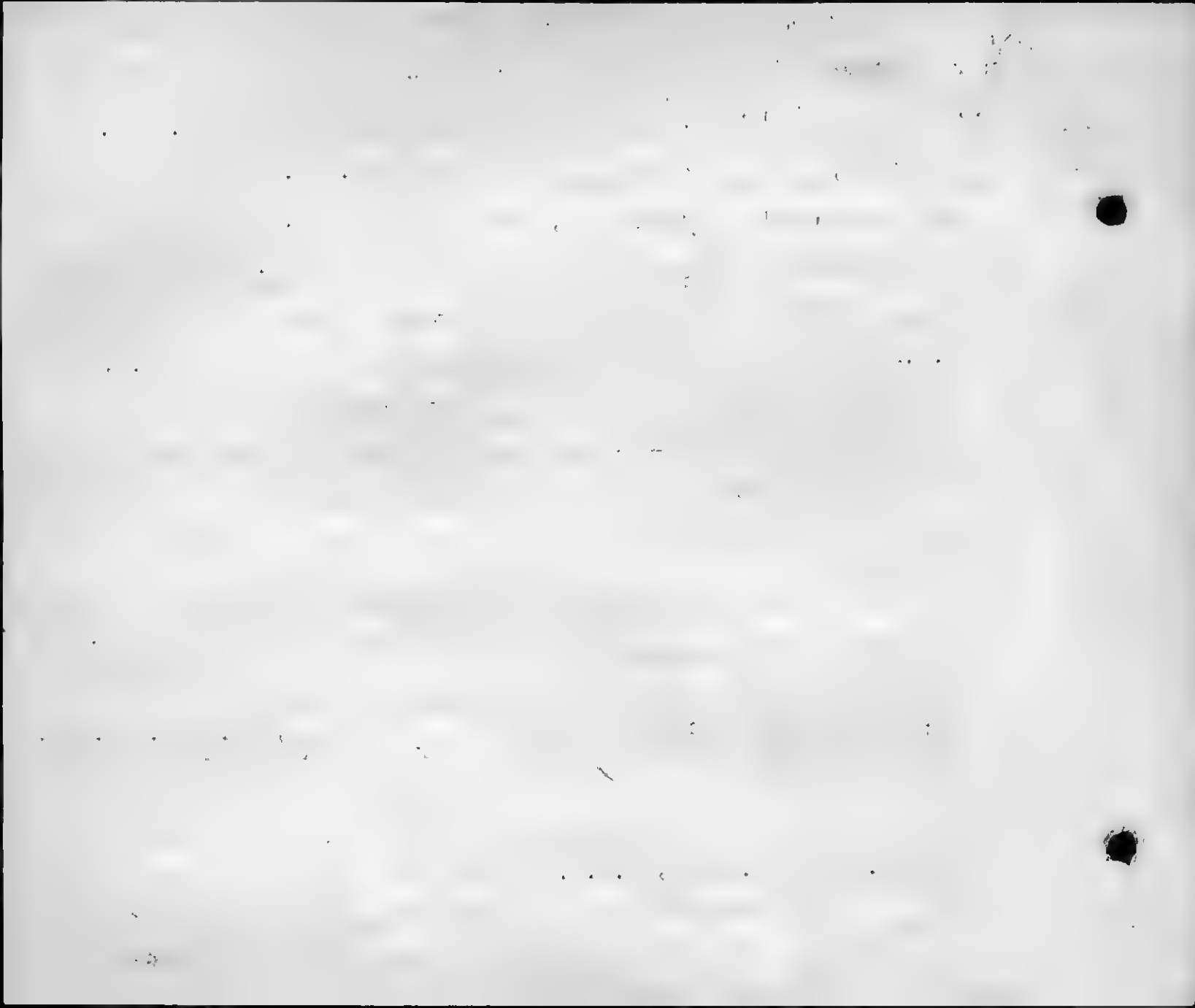
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Sole Occupant of auto that ran off road**
20c. TIME OF INJURY Month, Day, Year **11:40 PM 1/13/62** 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **On Hgwy** 20f. (City or town) **Meadows, Pr. Geo. Co. Md.** (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **James I. Boyd** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **1/13/62**
EXAMINER'S NAME (Type) **Dr. James I. Boyd, D.M.E.** Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **1/16/1962** 22c. NAME OF CEMETERY OR CREMATORY **ARLINGTON ARL CEM** 22d. LOCATION (City, town, or county) **ARLINGTON Virginia** (State)

23. FUNERAL DIRECTOR **W.W. Chambers Co - 517-1125 SE. WASH DC** ADDRESS 24a. REC'D BY REGISTRAR **JAN 17 '62** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kline**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by-the-funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

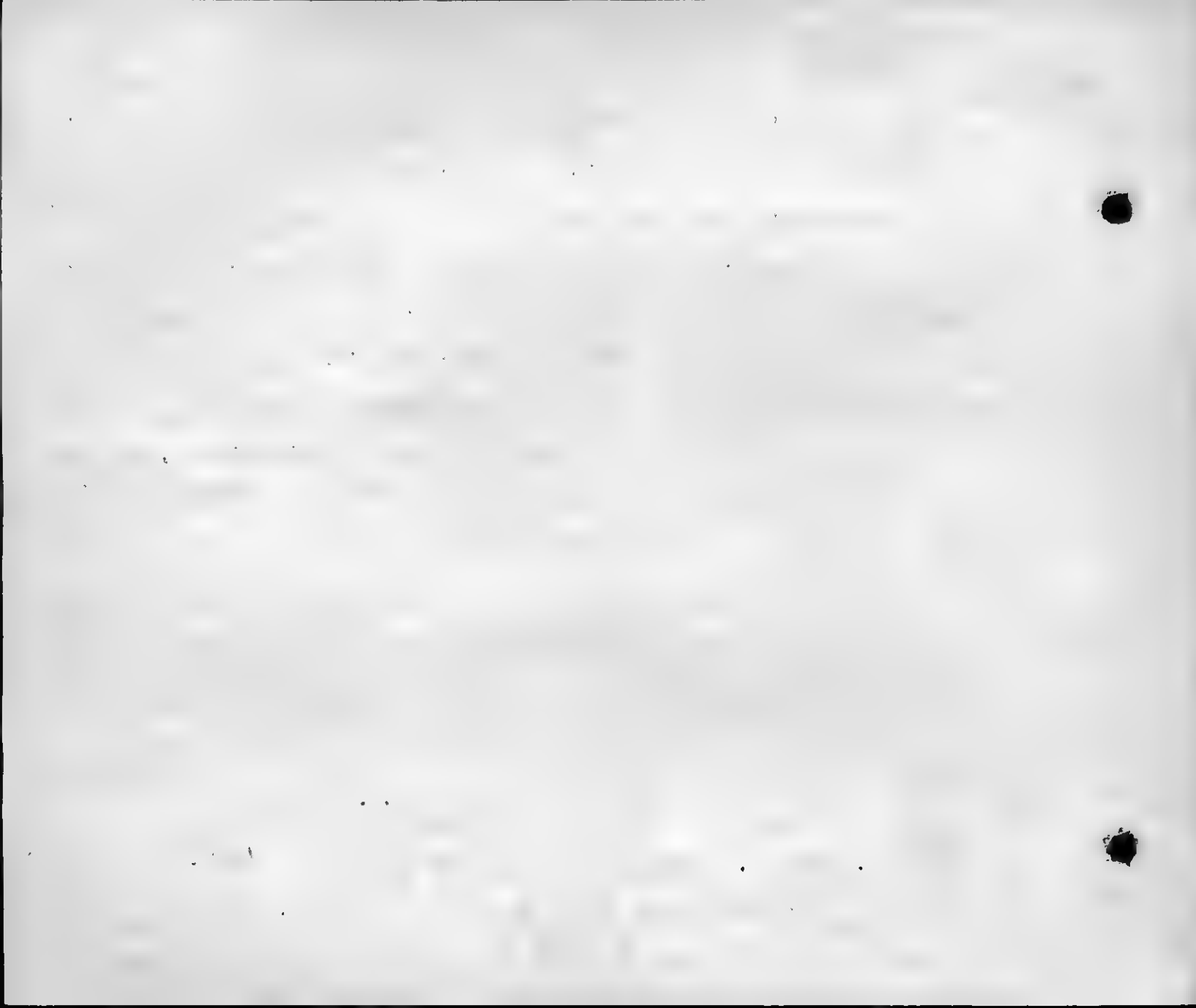
01073

CERTIFICATE OF DEATH

01062

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN b. <u>13 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> d. STREET ADDRESS <u>4415 Arnold Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Heidemarie</u> 4. DATE OF DEATH <u>January 17, 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 17, 1962</u> 9. AGE (in years if under 1 year, last birthday) <u>17</u> <u>19</u> <u>62</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Prince George's, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>Life</u>		13. FATHER'S NAME <u>Richard John Potocko</u> 14. MOTHER'S MAIDEN NAME <u>Monika Elizabeth Cordes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Mother</u> Address <u>4415 Arnold Road Suitland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7.2.2</u> DUE TO <u>Maternal Dystocia ventricular Bradycardia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Prematurity</u> DUE TO <u>LIFE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ATELECTASIA</u> <u>FOETAL</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>LIFE</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>1/17</u> to <u>1/17</u> , 1962, that (I) (we) last saw the deceased alive on <u>1/17</u> , 1962, and that death occurred at <u>6:10</u> , from the causes and on the date stated above.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7309 Rygo Rd Hyattsville Md.</u>		20f. (City or town) <u>Hyattsville</u> (County) <u>Prince George's</u> (State) <u>Md.</u>		20g. (City or town) <u>Hyattsville</u> (County) <u>Prince George's</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 1962, to <u>1/17</u> , 1962, that (I) (we) last saw the deceased alive on <u>1/17</u> , 1962, and that death occurred at <u>6:10</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Dr. Joseph J. McDonald</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph J. McDonald</u>		22b. DATE SIGNED <u>1/18/62</u>	
22d. ADDRESS <u>7309 Rygo Rd Hyattsville Md.</u>		22e. REC'D BY REGISTRAR <u>W. W. Chambers Co.</u> DATE <u>JAN 25 '62</u>		22f. REGISTRAR'S SIGNATURE <u>W. W. Chambers Co.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat'l. Cemetery</u>	
23d. LOCATION (City, town or county) <u>Suitland Md.</u>		23e. (State) <u>Md.</u>		23f. (City, town or county) <u>Suitland Md.</u>	
23g. (State) <u>Md.</u>		23h. (City, town or county) <u>Suitland Md.</u>		23i. (State) <u>Md.</u>	

207725111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01074

01065

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 2 yrs., 8 mos., & 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1722 21st St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest David Racz First Middle Last		4. DATE OF DEATH Month 1 Day 22 Year 19 62	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED & NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9/9/16 9. AGE (In years last birthday) 45 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Technician 10b. KIND OF BUSINESS OR INDUSTRY Unknown 11. BIRTHPLACE (County & State, or foreign country) Michigan 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Emil Racz 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown 16. SOCIAL SECURITY NO. 362-16-9617 17. INFORMANT Emma Kender Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemoptysis, 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Far advanced pulmonary tuberculosis (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 16 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/24/62 to 1/22/62, that (I) (we) last saw the deceased alive on 1/22/1962, and that death occurred at P.M., from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22b. DATE SIGNED 1/22/62 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial 23b. DATE THEREOF 1/25/62 23c. NAME OF CEMETERY OR CREMATORY Union 23d. LOCATION (City, town or county) Leesburg		25a. REC'D BY REGISTRAR JAN 26 '62 25b. REGISTRAR'S SIGNATURE William L. France	

X

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2
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

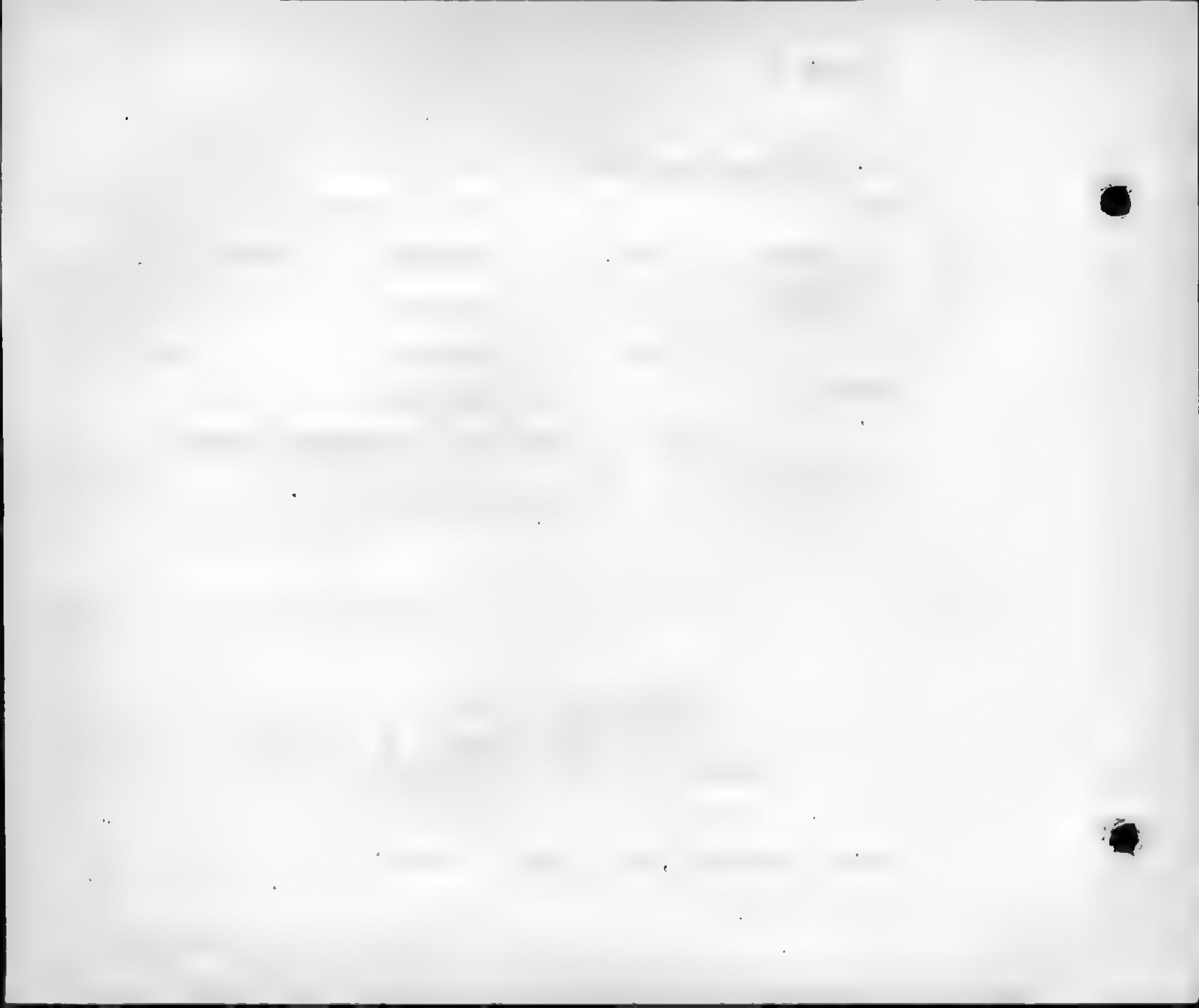
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01075

01066

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 3 MONTHS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS d. STREET ADDRESS 6065 WESTCHESTER COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle FULTON Last REYNOLDS		4. DATE OF DEATH Month JANUARY Day 15 Year 19 61			
5. SEX MALE	6 COLOR OR RACE CAUCASIAN	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 25 SEPTEMBER 1949	9. AGE (in years last birthday) 12 yrs.	IF UNDER 1 YEAR Months 12 Days 15 Hours 15 Min. 61
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) ALABAMA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME JOHN M REYNOLDS		14. MOTHER'S MAIDEN NAME SARAH FULTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17 INFORMANT JOHN M REYNOLDS (FATHER) Address SAME AS ITEM #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angiosarcoma Left Scapula DUE TO With Multiple Metastases Cand'tons if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 Mon. (c) 6 Mon.					INTERVAL BETWEEN ONSET AND DEATH 6 Mon.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 OCTOBER 1961 to 15 JANUARY 1962 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 15 JANUARY 1962 , and that death occurred at 645 M. from the causes and on the date stated above.					
22a SIGNATURE John A Hennesen Jr		22b. PHYSICIAN'S NAME (Type) JOHN A HENNESSEN JR, LCol USAF MC USAF HOSP, ANDREWS AIR FORCE BASE, MD		22c. ADDRESS W. W. Chambers Co 517-11 St SE	
22d. PHYSICIAN'S NAME (Type) JOHN A HENNESSEN JR, LCol USAF MC USAF HOSP, ANDREWS AIR FORCE BASE, MD		22e. ADDRESS W. W. Chambers Co 517-11 St SE		22f. ADDRESS W. W. Chambers Co 517-11 St SE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-62		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl	
23d. LOCATION (City, town, or county) 77 myer Va		23e. LOCATION (City, town, or county) 77 myer Va		23f. LOCATION (City, town, or county) 77 myer Va	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24b. ADDRESS W. W. Chambers Co 517-11 St SE		25a. REC'D BY REGISTRAR JAN 19 62	
24c. ADDRESS W. W. Chambers Co 517-11 St SE		24d. ADDRESS W. W. Chambers Co 517-11 St SE		25b. REGISTRAR'S SIGNATURE Arthur L. Hearn	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

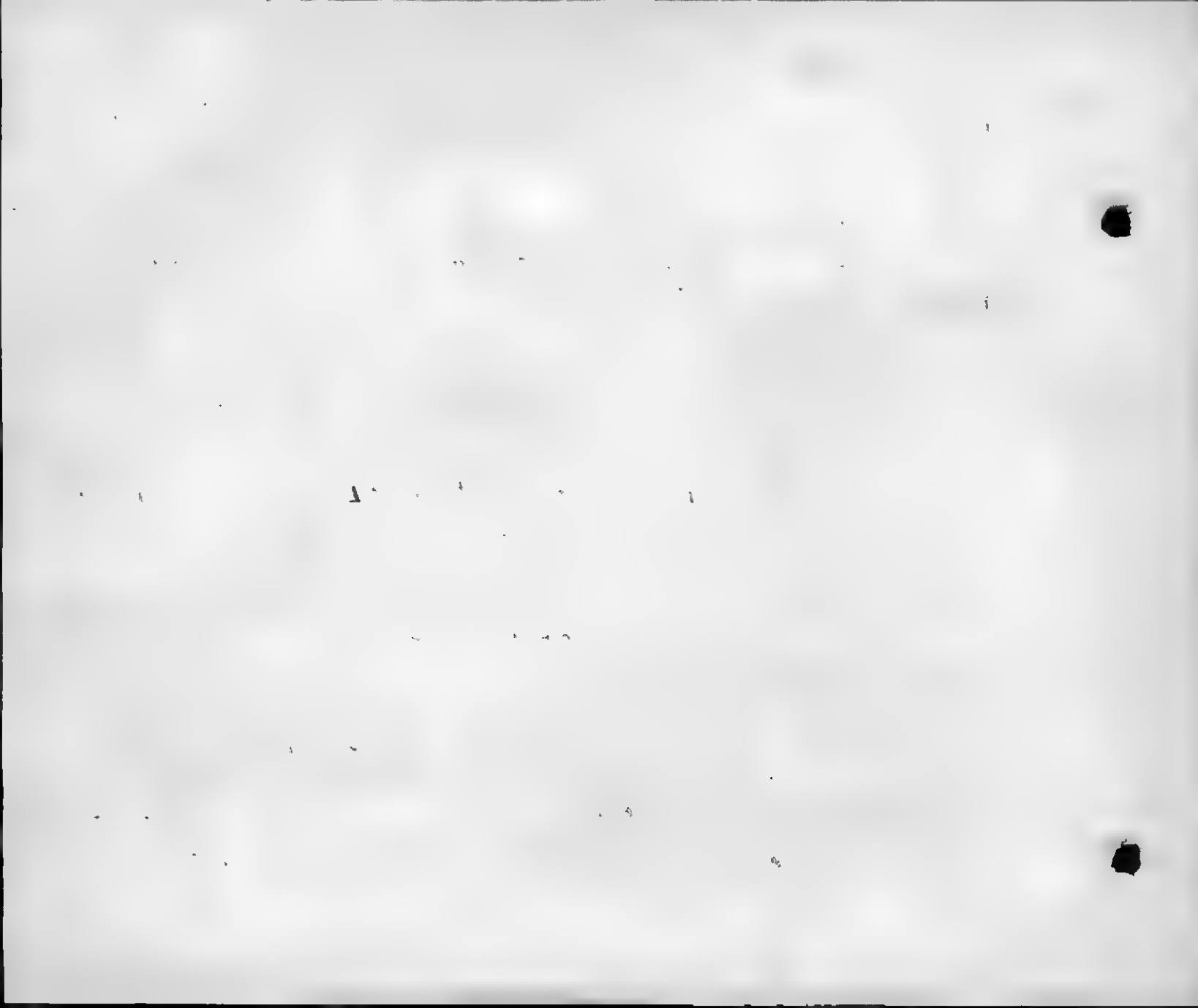
CERTIFICATE OF DEATH

01076

01067

1. PLACE OF DEATH e. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN It <u>2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laynel</u> d. STREET ADDRESS <u>344 MAINE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Viola St. Clair</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 9 1894</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month <u>JAN</u> Day <u>27</u> Year <u>1962</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>storekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>grocery store</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank A. Mulligan</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Mrs Pearl L. Black, Wash. D.C.</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Gaither</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (b) <u>Pneumatic Heart Disease</u> (c), stating the underlying cause last. <u>6 yrs</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Emphysema of Lungs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)			
21c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. 22c. PHYSICIAN'S NAME (Type) <u>Norman Donaldson</u> M.D.		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> 19 <u>62</u> to <u>1/27</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/27</u> 19 <u>62</u> and that death occurred at <u>2:40</u> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Donaldson</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Norman Donaldson</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3503 Pennyst Mt Rainier Md</u> 22e. DATE SIGNED <u>1/27/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1/30/62</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Donaldson</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery Laurel Maryland</u> 23d. LOCATION (City, town or county) (State) 25a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> 25b. REGISTRAR'S SIGNATURE DATE <u>FEB 2 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be filed with the State Department of Health within 24 hours after death. The law also requires that the death certificate be filed with the State Department of Health within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01077

CERTIFICATE OF DEATH

01068

Item 14 Film 8305 1/18/62

1. PLACE OF DEATH

a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverview

c. LENGTH OF STAY IN TB

3 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Beland Memorial Hosp

3. NAME OF DECEASED

(Type or print)

Joseph

First

Middle

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED

8. DATE OF BIRTH

12-2-84

9. AGE (In years last birthday)

77 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Storekeeper Grocery Store

10b. KIND OF BUSINESS OR INDUSTRY

Storekeeper Grocery Store

11. BIRTHPLACE (County & State, or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ceaser Salute

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Ne Sp Record

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

4-4-3X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Acute Congestive Heart Failure
Hypertensive & Coronary sclerosis
CHD & R+ Hemiplegia

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1959 to 1962, that (I) (we) last saw the deceased alive on 1-10-62 and that death occurred at 7 PM, from the causes and on the date stated above.

22a. SIGNATURE

W. Etienne

22c. PHYSICIAN'S NAME (Type)

W. Etienne

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

College Park, Md.

22b. DATE SIGNED

1/10/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Entombment

23b. DATE THEREOF

1/13/62

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Mausoleum

23d. LOCATION (City, town or county)

Colmar Manor, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

3 Donald Sma Hyattsville, Md.

ADDRESS

25a. REC'D BY REGISTRAR

DATE JAN 15 '62

25b. REGISTRAR'S SIGNATURE

Arthur L. Harris



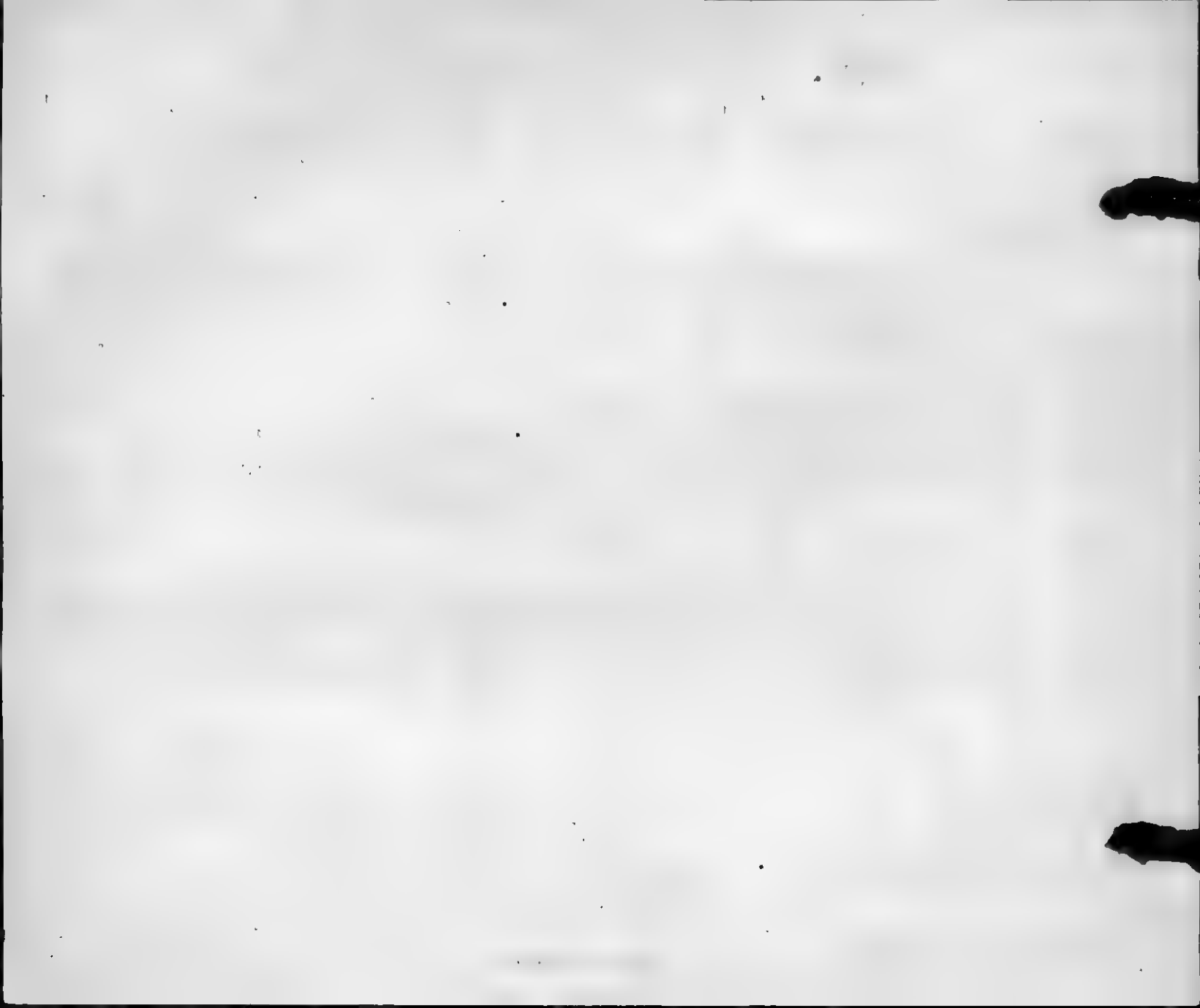
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH
MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Capital Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial		A. STREET ADDRESS 16224 Kingston Avenue	
3. NAME OF DECEASED (Type or print) Benneville William Scala		4. DATE OF DEATH January 20 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1882
9. AGE (In years and birthday) 79 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Francis Maria Scala		14. MOTHER'S MAIDEN NAME Olivia Arth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Julia Moss Scala, same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 22 '62	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) Wash. D.C.
23. FUNERAL DIRECTOR J. J. Costello, 1722 N. Cap. U. Way, Bk		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
		DATE JAN 22 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01079

01070

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Prince	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days 9hr.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General		e. STREET ADDRESS 9014 Ardmore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Jan. 7 1962		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-19 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-DC Metropolitan Policeman		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		9. AGE (In years last birthday) 68	
11. BIRTHPLACE (Country & State, if country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Franz Scheuring	
14. MOTHER'S MAIDEN NAME Elizabeth Knarvy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 1		16. SOCIAL SECURITY NO 579-01-2511	
17. INFORMANT Daughter		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal shut down bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cardiovascular degenerative disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 44		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4-62 , 19....., to 1-7-62 , 19....., that (I) (we) last saw the deceased alive on 1-7-62 , 19....., and that death occurred at 8:45 A.M. from the causes and on the date stated above.		22a. SIGNATURE William B. Hagan M.D.		22b. DATE SIGNED 1-7-62	
22c. PHYSICIAN'S NAME (Type) Dr. William B Hagan		22d. ADDRESS 3303 Perry Street, Mt. Rainier, Md.		22e. REC'D BY REGISTRAR JAN 9 62	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1/9/62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City, town or county) Pr. Geo. Co., Maryland		23e. REGISTRAR'S SIGNATURE The S.H. Hines Co. 2901 14th ST. N.W.		23f. REGISTRAR'S SIGNATURE Jan 9 62	

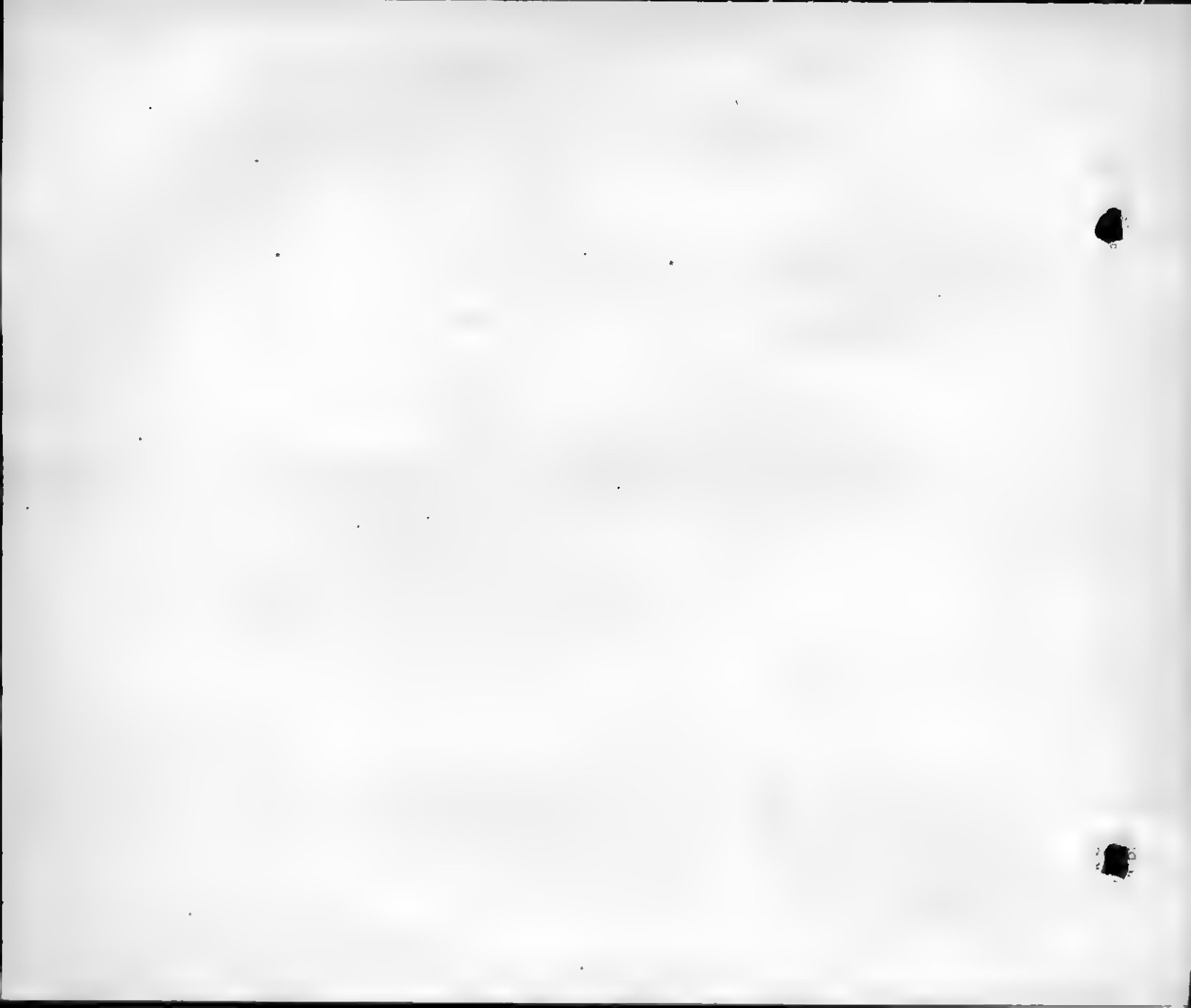




01080
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01071

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 71 College Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4615 Clemson Road				d. STREET ADDRESS 14615 Clemson Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EDITH S. SELLMAN				4. DATE OF DEATH Month Day Year Jan. 19 19 62			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1876	
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Basil Smith				14. MOTHER'S MAIDEN NAME Frances Chilcote			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO none		17. INFORMANT Louise Hughes	
				Address College Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4- acute congestive heart failure DUE TO (b) arterial-sclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs 7	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 1-19-62, and that death occurred at 4:00 M, from the causes and on the date stated above.							
22a. SIGNATURE W. C. Etienne				M.D. ATTENDING PHYSICIAN MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. C. ETIENNE				22d. ADDRESS College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 22, 1962		23c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		23d. LOCATION (City, town, or county) (State) Beltsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE JAN 23 '62	
				25b. REGISTRAR'S SIGNATURE Albert S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01081

Item 2 filing G.C. 1/15/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 11072

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
c. LENGTH OF STAY IN 1b 4 1/2 MOS.		d. STREET ADDRESS 3304 LANCER DRIVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FERRINA NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROSE RITA SHARKEY		4. DATE OF DEATH Month Day Year JAN 6 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 10 1955
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Sharkey		14. MOTHER'S MAIDEN NAME Mo. Jean Sharkey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mo. Mrs. Jean Sharkey		Address 4363 Twickenham Rd. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA HYPOSTATIC 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INANITION DUE TO (c) CEREBRAL PALSY (TETRAPLEGIC)			INTERVAL BETWEEN ONSET AND DEATH 4 MOS LIFE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUGUST 1961 to JAN 6 1962 that I last saw the deceased alive on Jan 5 1962 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph J. McDonald M.D.		ADDRESS (Street, city or town, state) 7309 Riggs Rd. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) JOSEPH J. McDONALD M.D.		DATE SIGNED 1/6/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-9-1962	22c. NAME OF CEMETERY OR CREMATORY Washington National	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., Riverdale, Md.		24a. REC'D BY REGISTRAR JAN 9 1962	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



FOR STATE
HEALTH DEPT.

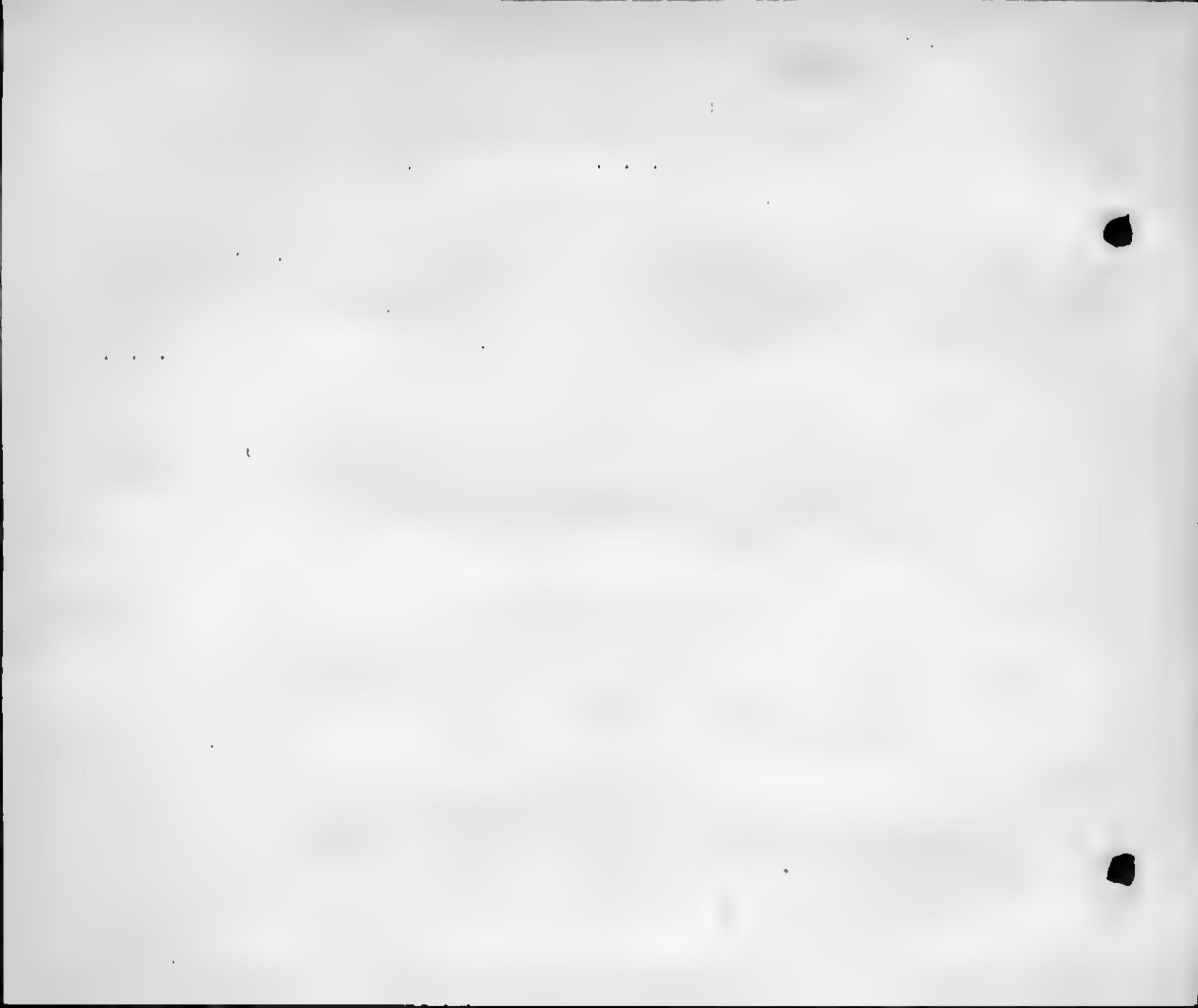
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>01082</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01073</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)</div> <div>a. STATE</div> </div> </div>									
<div> <div>Prince George's</div> <div>MARYLAND</div> </div>					<div> <div>Maryland</div> <div>Prince George's</div> </div>				
<div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Cheverly</div> </div>					<div> <div>c. LENGTH OF STAY IN 1b</div> <div>D.O.A.</div> </div>				
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Prince George's General Hospital</div> </div>					<div> <div>d. STREET ADDRESS</div> <div>30 Cedar Heights</div> </div>				
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>Adrian Shorter</div> </div>					<div> <div>4. DATE OF DEATH</div> <div>January 17 19 62</div> </div>				
<div> <div>5. SEX</div> <div>Male</div> </div>					<div> <div>6. COLOR OR RACE</div> <div>Colored</div> </div>				
<div> <div>7. MARRIED</div> <div><input type="checkbox"/> NEVER MARRIED</div> </div>					<div> <div>8. DATE OF BIRTH</div> <div>October 3, 1961</div> </div>				
<div> <div>9. AGE (In years last birthday)</div> <div>3</div> </div>					<div> <div>10. IF UNDER 1 YEAR</div> <div>Months 3 Days 14</div> </div>				
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>None</div> </div>					<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>None</div> </div>				
<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div> </div>					<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>				
<div> <div>13. FATHER'S NAME</div> <div>William Henry Shorter</div> </div>					<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Helen Glichrist</div> </div>				
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> </div>					<div> <div>16. SOCIAL SECURITY NO.</div> <div>None</div> </div>				
<div> <div>17. INFORMANT</div> <div>William Henry Shorter, same as # 2</div> </div>					<div> <div>Address</div> </div>				
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</div> <div>Pneumonia</div> </div> <div> <div>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last, (c)</div> </div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> </div> </div>									
<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>									
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> </div>					<div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div>				
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour e.m. p.m.</div> <div>19</div> </div>					<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div>				
<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> </div>					<div> <div>20f. (City or town) (County) (State)</div> </div>				
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>									
<div> <div>ACTUAL SIGNATURE</div> <div>James I. Boyd</div> </div>					<div> <div>ASS. STANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> </div>				
<div> <div>NAME (Type)</div> <div>James I. Boyd</div> </div>					<div> <div>DATE SIGNED</div> <div>1/17/62</div> </div>				
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>1-20-62 Nat Harmony</div> </div>					<div> <div>22b. DATE THEREOF</div> <div>1-20-62</div> </div>				
<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Nat Harmony</div> </div>					<div> <div>22d. LOCATION (City, town, or country) (State)</div> <div>Highland Park Md</div> </div>				
<div> <div>23. FUNERAL DIRECTOR</div> <div>Henry Washington & Sons 4925 Dean Ave NE</div> </div>					<div> <div>24a. REC'D BY REGISTRAR</div> <div>JAN 22 '62</div> </div>				
<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Kram</div> </div>					<div> <div>DATE</div> </div>				

20:7



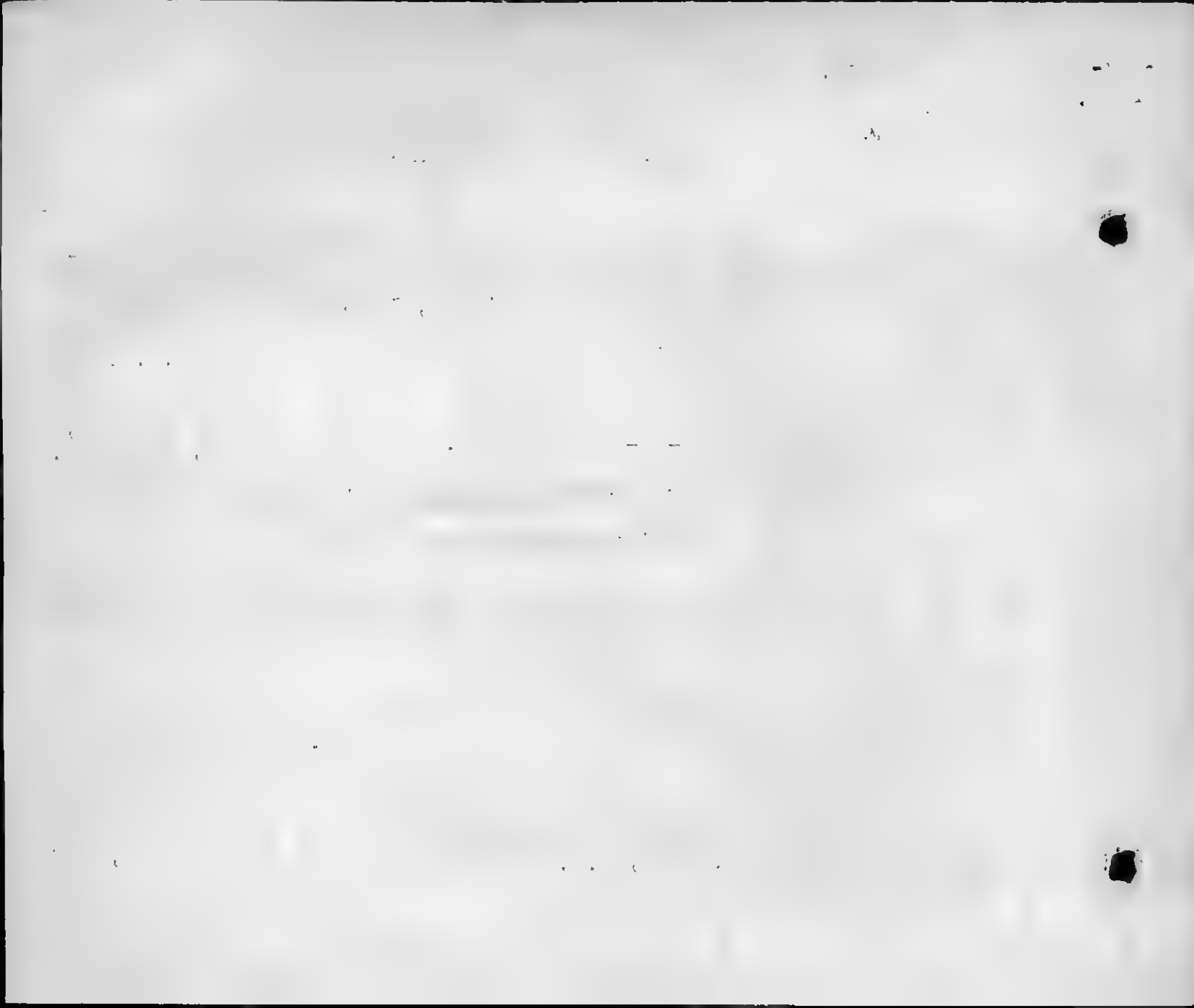
FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9,60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01074											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine						c. LENGTH OF STAY in 1b Life					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 1 Rural						d. STREET ADDRESS Route 1 Rural					
3. NAME OF DECEASED (Type or print) GUY FRANCIS SIMMS						4. DATE OF DEATH Month January Day 7 Year 1962					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1895		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar SIMMS						14. MOTHER'S MAIDEN NAME Amanda FORD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 212-14-2595					
17. INFORMANT Perry F. Simms,						Address Javier Road, Fairfax, Virginia.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure											
DUE TO (b) Cardiovascular renal disease											
DUE TO (c) 											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
21. ACTUAL SIGNATURE James I. Boyd						21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
21. EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						21. DATE SIGNED January 7, 1961					
21. Address (Street, city, town, or county)						21. (State)					
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF 1-11-62		22c. NAME OF CEMETERY OR CREMATORY CLINTON, MD.		22d. LOCATION (City, town, or country)	
23. FUNERAL DIRECTOR HUNT Funeral Home, Hunt Road						23. ADDRESS		24a. REC'D BY REGISTRAR JAN 12 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

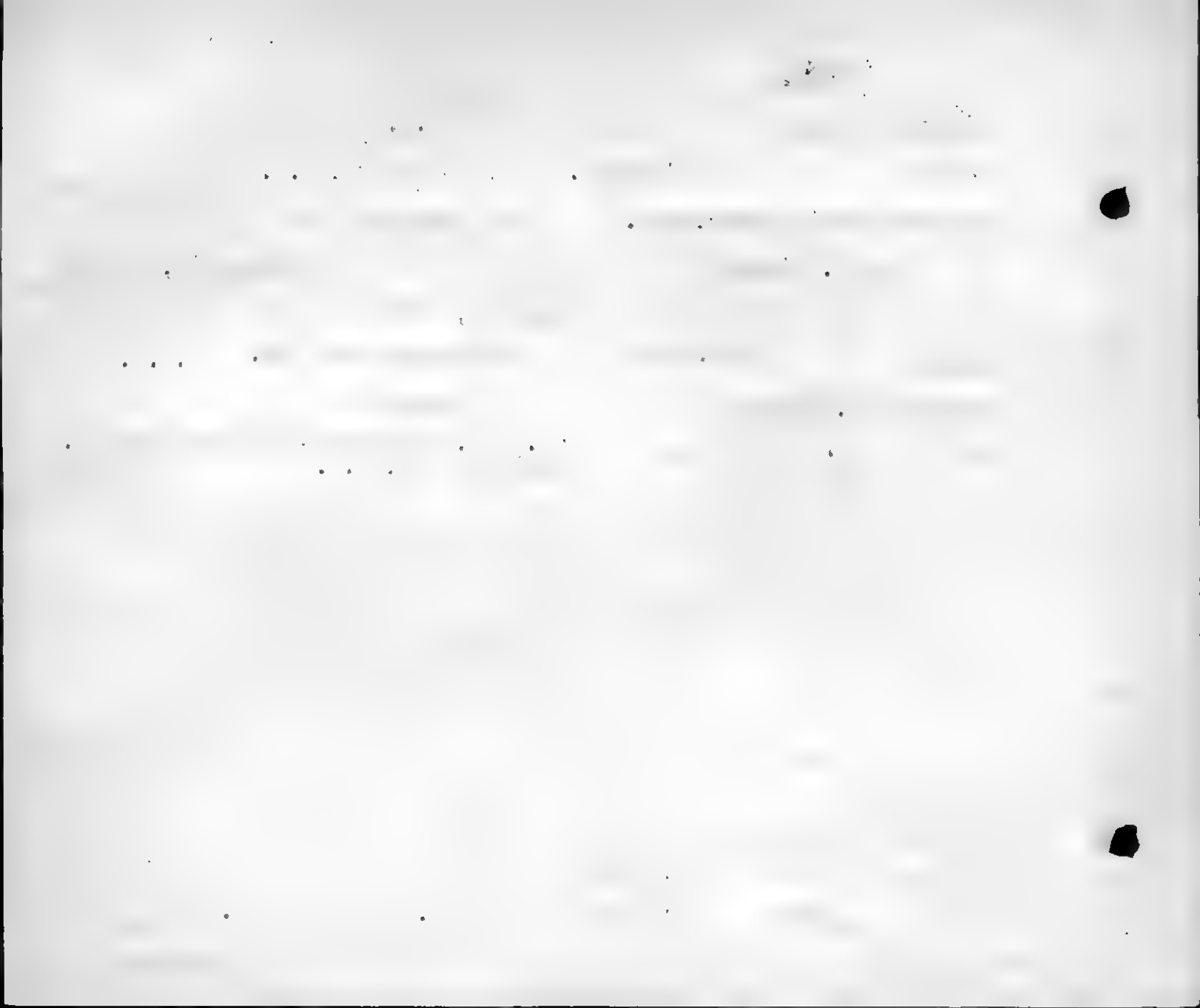
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01084

01075

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN It <u>2 yrs Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home, Inc.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 28, D.C.</u> d. STREET ADDRESS <u>7411 Hansford St</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Siobers</u>		6. DATE OF BIRTH <u>Jan 15, 1880</u>		9. AGE (In years last birthday) <u>82</u> yrs. Months Days Hours Min.	
5. SEX <u>F</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick G. George</u>		14. MOTHER'S MAIDEN NAME <u>Sautner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Geo. Belsinger</u>		Address <u>7411 Hansford St. Washington 28, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (a), stating the underlying cause last. (c) <u>20 yrs.</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1962</u> to <u>July 15, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 15, 1962</u> , and that death occurred at <u>7:58 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Leo H. Mugmon</u> M.D.	
22c. PHYSICIAN'S NAME (Type) <u>LEO H. MUGMON M.D.</u>		22b. DATE SIGNED <u>1/15/62</u>		22d. ADDRESS <u>2711 FAIRVIEW ST. HICKORY HIGHTS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cmty.</u>	
23d. LOCATION (City, town or county) <u>Woodlawn Md.</u>		23e. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u>		24a. ADDRESS <u>4101 Edmonson Ave</u>		24b. DATE <u>JAN 17 '62</u>	



1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with file PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01085 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01076

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN 1b 2.6.62		d. STREET ADDRESS 223 9th Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Everett Randolph Smith		4. DATE OF DEATH Month January Day 27 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1912
9. AGE (In years last birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Cleveland Smith		14. MOTHER'S MAIDEN NAME Edith Bradford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 1202 Snowden Place	
17. INFORMANT Ruby Virginia Smith, Laurel, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute carbon monoxide poisoning DUE TO (b) Smoke from fire DUE TO (c) Smoke from fire Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Occupant of a house that caught on fire	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of a house that caught on fire	
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 1/27/1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Laurel P. G.		20g. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/62	
22c. NAME OF CEMETERY OR CREMATORY Ing Hill Cemetery		22d. LOCATION (City, town, or country) (State) Laurel Md	
23. FUNERAL DIRECTOR De Witt Donaldson, Laurel, Md		24. REC'D BY REGISTRAR FEB 2 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE SIGNED December 28, 1962	

MEDICAL CERTIFICATION

ACTUAL

EXAMINER'S NAME (Type)

JAMES I. BOYD, M. D.

M.D.

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

December 28, 1962



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01086

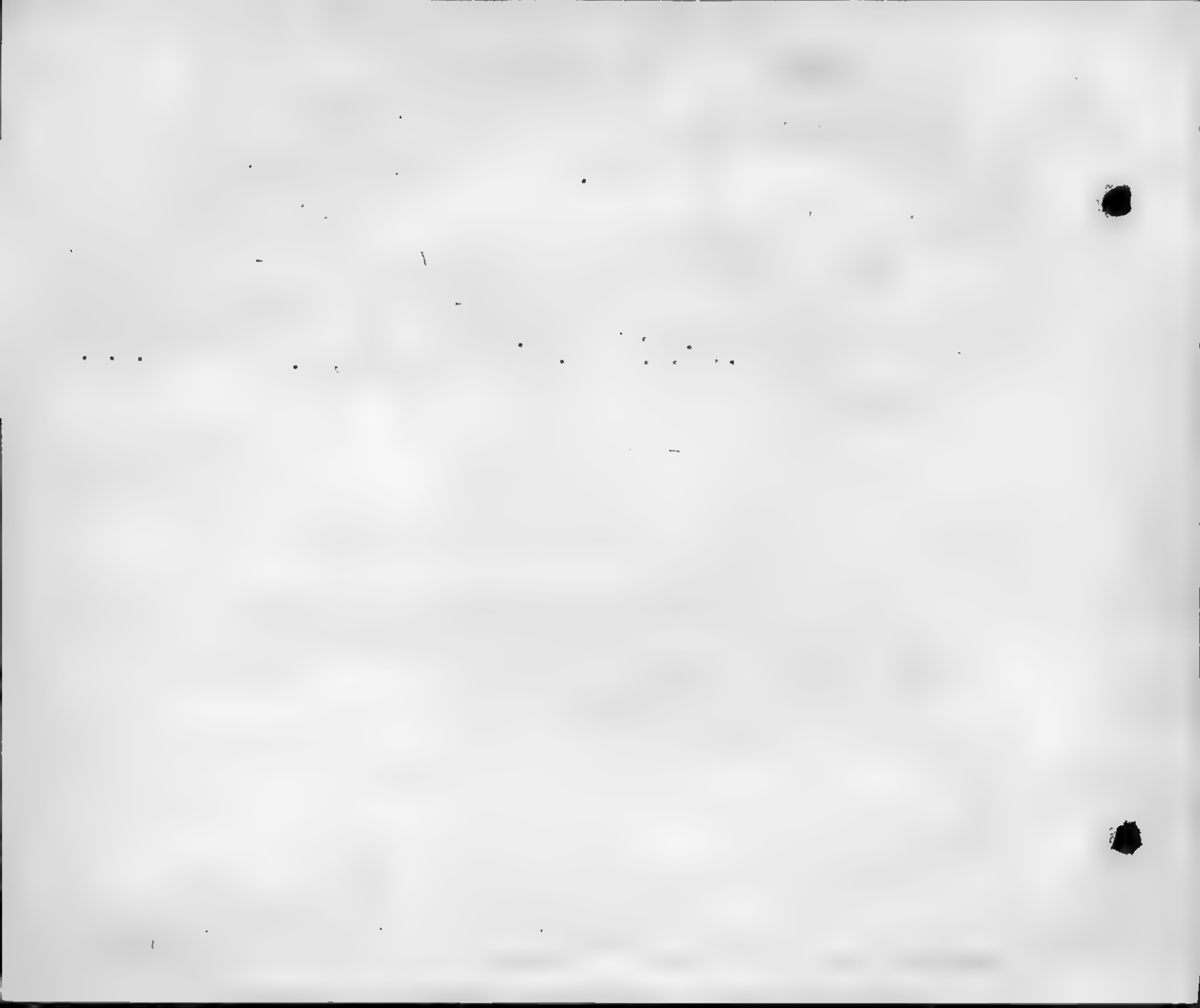
Item 8 Film G305 1/18/62 mb

01077

1. PLACE OF DEATH a. COUNTY Prince George's County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park Maryland		2. USUAL RESIDENCE (Where deceased lived, if last before death, residence before admission) a. STATE Maryland b. COUNTY PG c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park Maryland d. STREET ADDRESS 7323 Radcliff Drive	
3. NAME OF DECEASED (Type or print) Smith Melvin H.		4. DATE OF DEATH Month Day Year 1-10-1962		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1901		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Traffic Officer, U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Smith		14. MOTHER'S MAIDEN NAME ? Hobbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 719-03-4013		17. INFORMANT Beatrice Beall Smith (above address)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) severe atherosclerotic H.D. DUE TO (c) Mild Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1-10-1962 INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-10-1962 to 1-10-1962 , that (I) (we) last saw the deceased alive on 1-10-1962 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Waldo B. Meyers		22b. DATE SIGNED 1-10-62		22c. PHYSICIAN'S NAME (Type) Waldo B. Meyers	
22d. ADDRESS 3503 Pety St. Mt Rainier Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 1/13/62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		24b. ADDRESS Mt Rainier Md.		25a. REC'D BY REGISTRAR DATE JAN 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

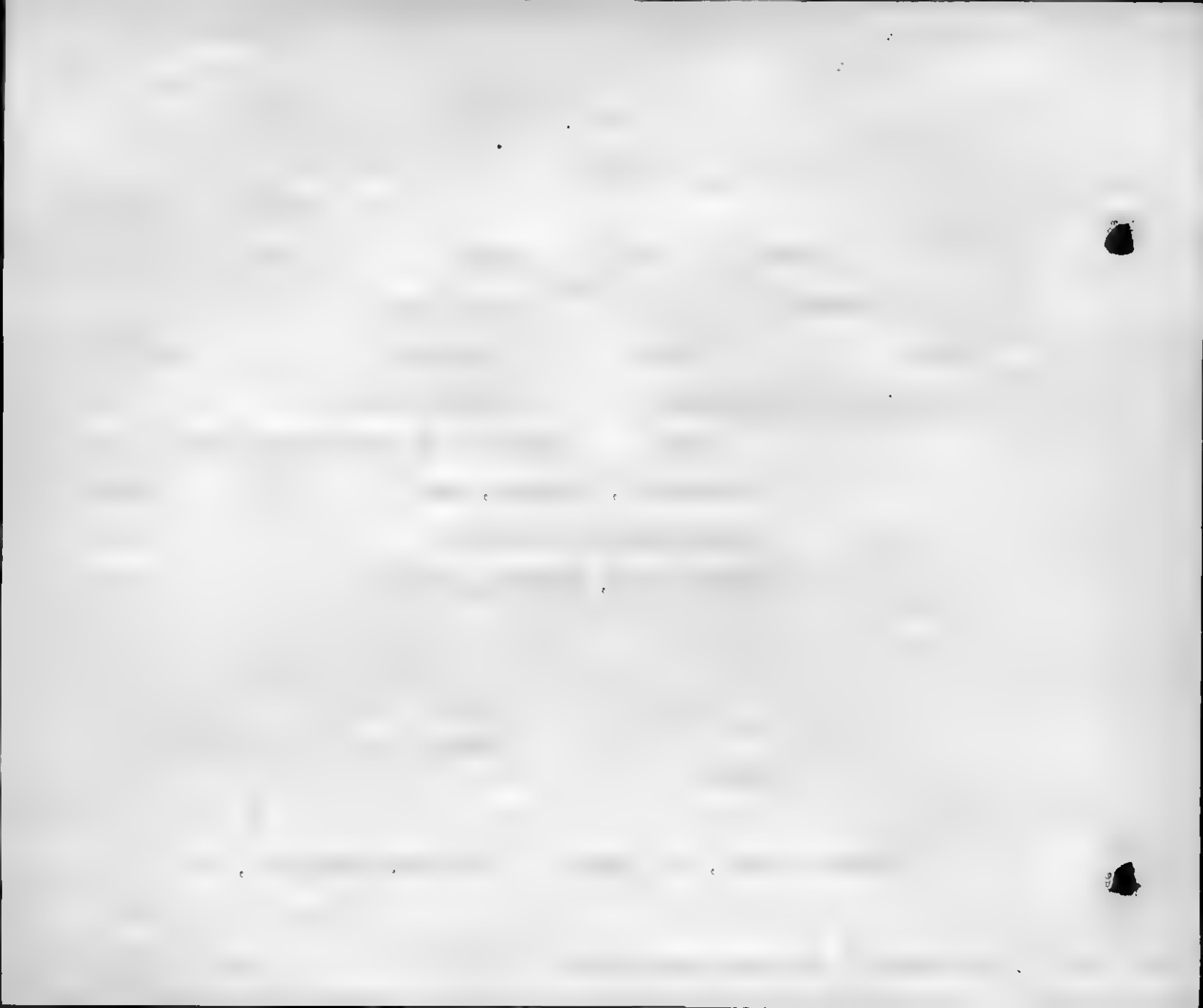


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return page 3 with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01087					01078				
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 28 MINUTES d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 607 SOUTHERN AVENUE SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY KURT SOLLARS					4. DATE OF DEATH Month Day Year JANUARY 4 19 62				
5. SEX MALE					6. COLOR OR RACE CAUCASIAN				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 15 JUNE 1961				
9. AGE (In years last birthday) 1					10. AGE (In years last birthday) 6				
11. BIRTHPLACE (County & State, or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? UNITED STATES				
13. FATHER'S NAME KENNETH SYLVESTER SOLLARS					14. MOTHER'S MAIDEN NAME JOANN PENDLETON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. NONE				
17. INFORMANT KENNETH S SOLLARS (FATHER)					Address SAME AS ITEM #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS, BILATERAL, ACUTE Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) TRACHEOBRONCHITIS, ACUTE DUE TO (c) OTITIS MEDIA, BILATERAL, ACUTE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 HRS. 24 HRS. 48 HRS.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 JANUARY, 19 62 to 4 JANUARY, 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 JANUARY, 19 62 , and that death occurred at 408B , from the causes and on the date stated above.									
22a. SIGNATURE Hestley D. Stepp					22b. DATE SIGNED 4 JAN 62				
22c. PHYSICIAN'S NAME (Type) HESTLEY D. STEPP, Capt USAF MC					22d. ADDRESS USAF HOSP, ANDREWS AFB, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1/8/62				
23c. NAME OF CEMETERY OR CREMATORY Longmont Colo.					23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home					25a. REC'D BY REGISTRAR DATE JAN 8 '62				
25b. REGISTRAR'S SIGNATURE Arthur S. Hume									

205-5121-4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01088

CERTIFICATE OF DEATH

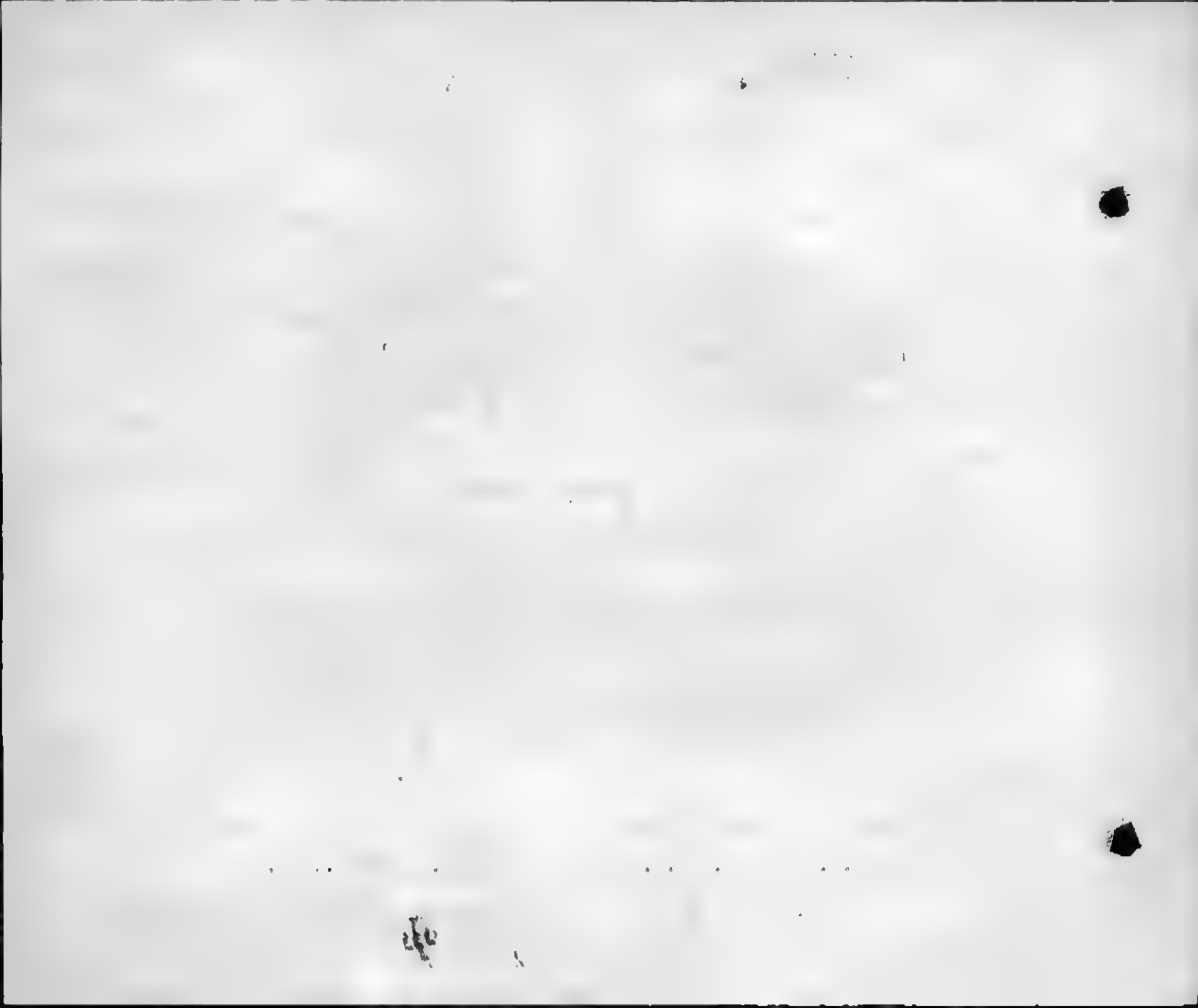
01079

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4915 - 40th Place</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George S Sollers</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>20 Aug 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH <u>Jan 22 1962</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer Merchant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George W. Sollers</u> 14. MOTHER'S MAIDEN NAME <u>Susie L. Childs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>578-05-7408</u> 17. INFORMANT <u>Mrs Sara S. Sollers</u> Address <u>Same as # 2</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Arteriosclerosis Heart Diseases & Sclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> <u>1962</u> to <u>1-22</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>1-22</u> <u>1962</u> , and that death occurred at <u>6:00 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George Hageage</u> M.D. 22b. DATE SIGNED <u>1-22-62</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Hageage, M.D.</u> 22d. ADDRESS <u>Mt. Rainier, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-26-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>5801 Cleveland Ave</u> <u>Reindeer, Md</u>				25a. REC'D BY REGISTRAR <u>JAN 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

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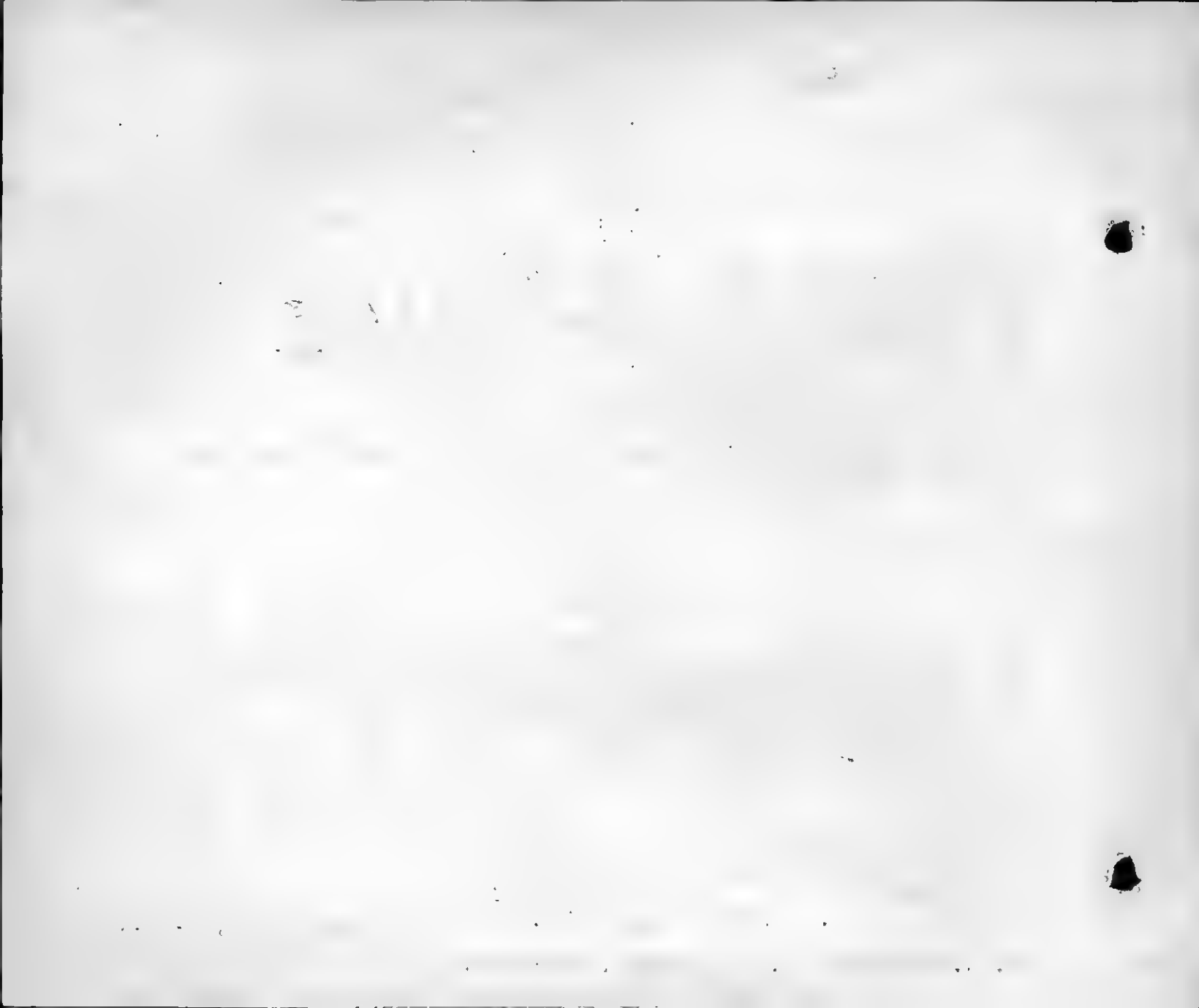
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01089											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>70 days</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>7500 Adelphi Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Lucy Spink</u>				4. DATE OF DEATH <u>Jan 9th 1962</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-88</u> <u>75</u> yrs.		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Ca of ovaries with general Metastases</u> <u>175.0</u> DUE TO (b) <u>Ca of ovaries with general Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Ca of ovaries with general Metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 2 years</u>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 9, 1962</u> to <u>Jan 9, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 9, 1962</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>L W Malin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Jan 9, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>				22d. ADDRESS <u>Riverdale, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 12, 1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery Washington, D. C.</u>			
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>				ADDRESS <u>Riverdale, Maryland</u>				25a. REC'D BY REGISTRAR <u>JAN 11 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>											

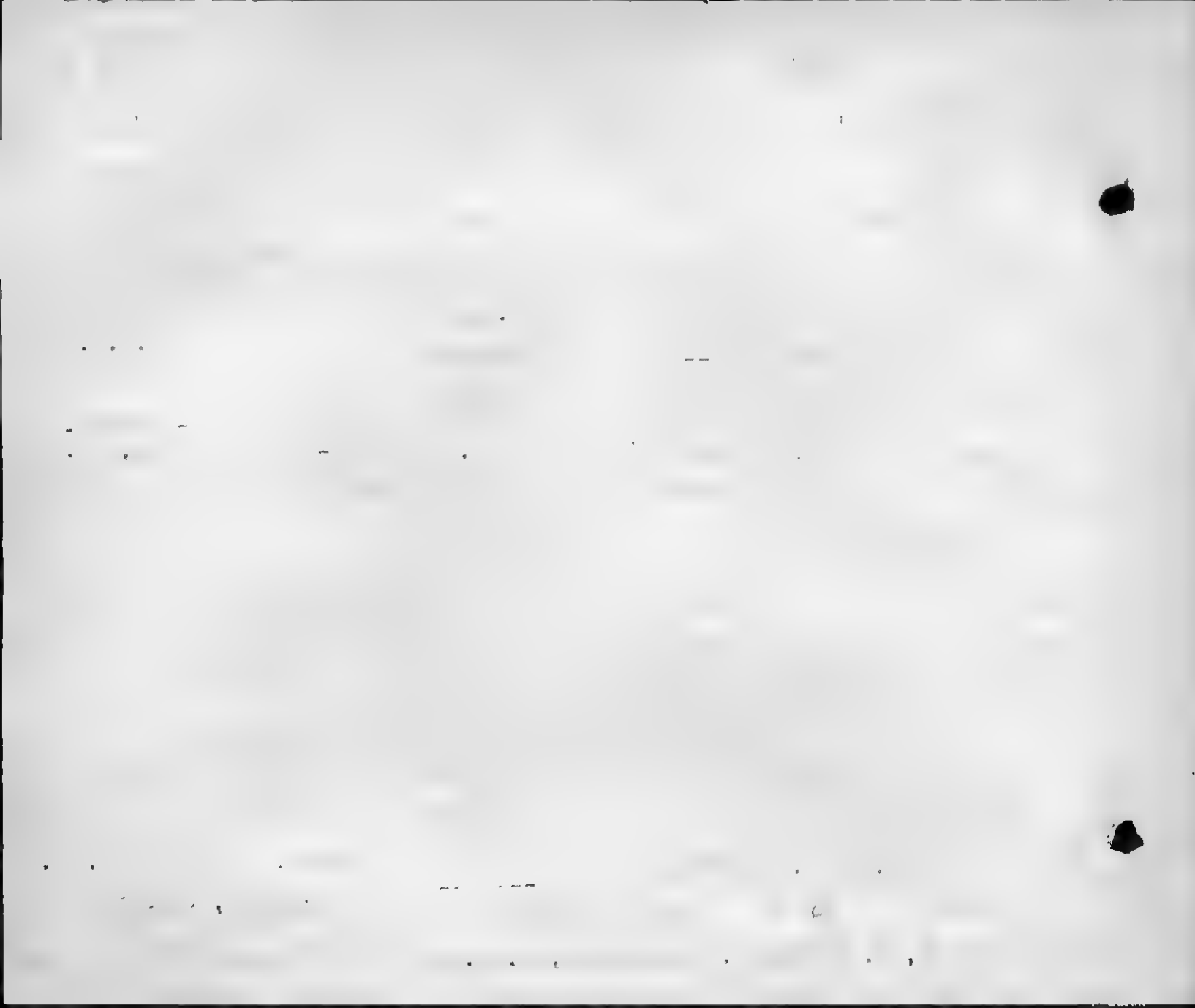


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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01096
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01081

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 520 - 68th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First Middle Last Spletter		4. DATE OF DEATH January 24 1962 Month Day Year	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1890 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watch Repairer		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WW #1		16. SOCIAL SECURITY NO. unobtainable	
17. INFORMANT Alice J. Spletter-Seat Pleasant, Md.		Address 520-68th St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) Cerebral Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/21, 1962, to 1/24, 1962, that (I) (we) last saw the deceased alive on 1/24, 1962, and that death occurred at 1 P.M., from the causes and on the date stated above.			
22. SIGNATURE Max M. Herzberg 22c. PHYSICIAN'S NAME (Type) Dr. Max M. Herzberg		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 7016 Greig Street, Hillcrest Hgts. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		25. REC'D BY REGISTRAR JAN 29 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

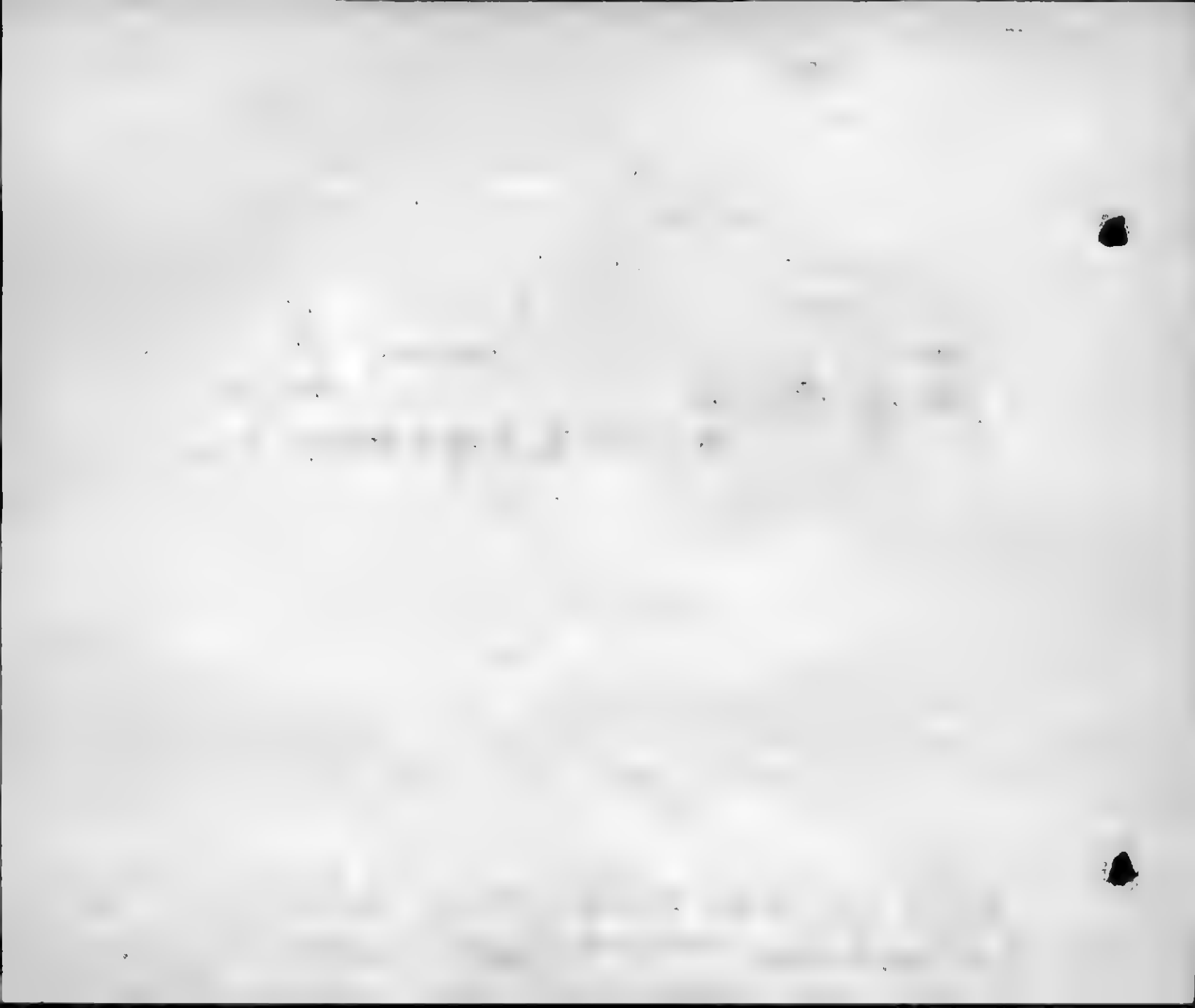
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01091

01082

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>8122 - 14th Ave.</u>		3. NAME OF DECEASED (Type or print) <u>William J. Steinbaugh</u> First Middle Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-01</u> Yrs. <u>60</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>14</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u> 11. BIRTH PLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wm. Steinbaugh</u> 14. MOTHER'S MAIDEN NAME <u>Morrison</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO <u>378-10-6338</u> 17. INFORMANT <u>Mrs. Dorothy R. Steinbaugh (same as #2)</u> Address <u></u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>42091</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 12, 1962 to JAN. 14, 1962</u> that (I) (we) last saw the deceased alive on <u>JAN. 14, 1962</u> and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>R.D. Braker M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>R.D. Braker, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Prince Georges Hospital, Chesley, Md.</u>		22b. DATE SIGNED <u>1-15-62</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan-17-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fl. Luciani Cemetery</u> 23d. LOCATION (City, town or county) <u>Bledauburg Rd. Md.</u> (State) <u></u>		24. REC'D BY REGISTRAR <u>Arthur S. Kessel</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kessel</u> DATE <u>JAN 17 '62</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

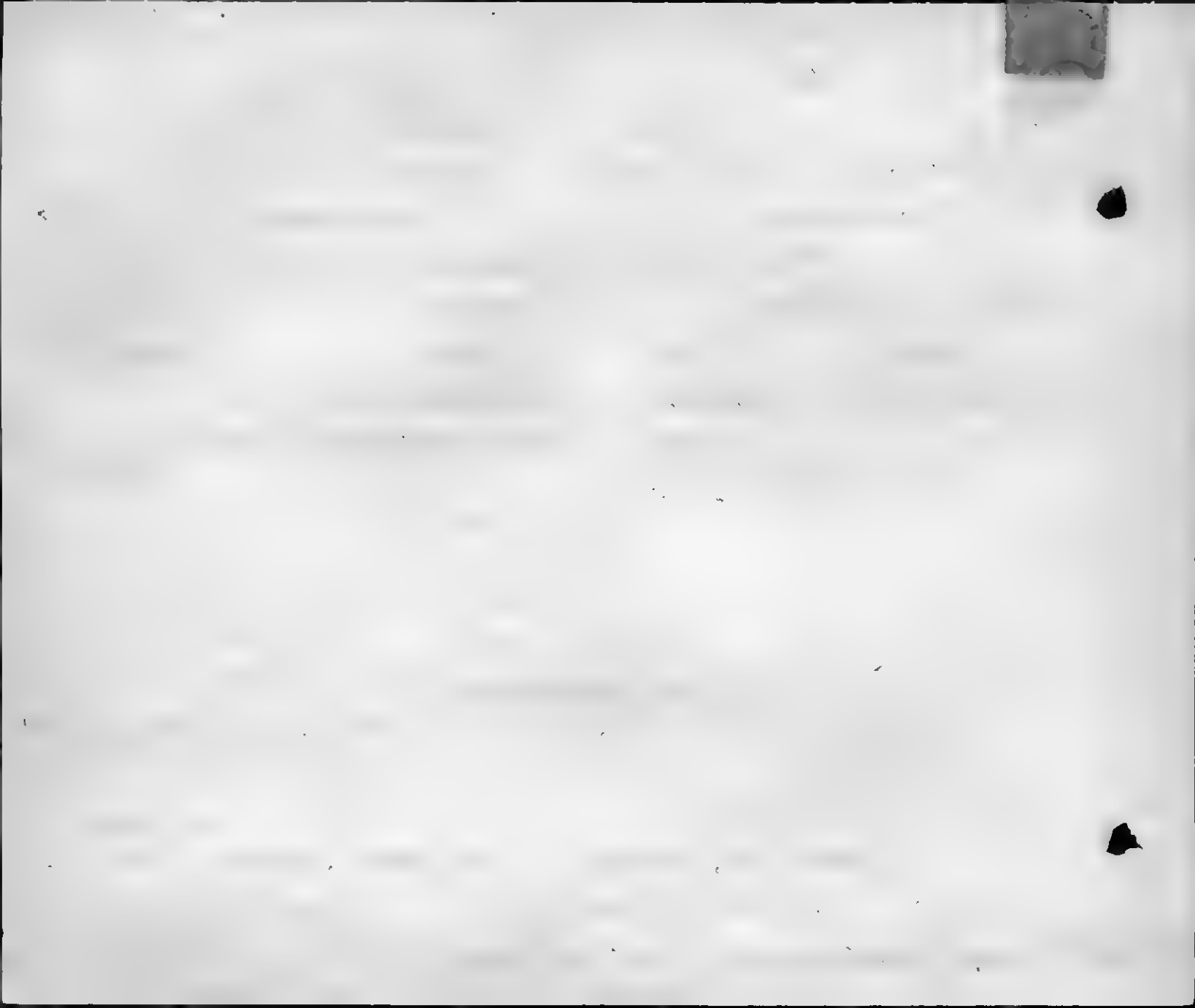
01092

01083

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE</u> c. LENGTH OF STAY IN 1b <u>13 HOURS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>US AIR FORCE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u> d. STREET ADDRESS <u>5103 SUITLAND ROAD SE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ALTON</u> Last <u>STOWE</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>23</u> Year <u>19 62</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>23 AUGUST 1951</u>			
9. AGE (In years last birthday) <u>10 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>EDMUND LEON STOWE (DECEASED)</u>		14. MOTHER'S MAIDEN NAME <u>MARY E LUCAS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARY E STOWE (MOTHER)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>INTRACRANIAL INJURY</u> (b) <u>BEING STRUCK BY AUTOMOBILE</u> (c) <u>13 HR HONIN</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STRUCK BY AUTOMOBILE</u>							
20c. TIME OF INJURY Hour <u>6:15</u> a.m. <u>23 JANUARY 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>			
20f. (City or town) <u>MURKINSIDE</u>		(County) <u>PRINCE GEORGES</u>		(State) <u>MD</u>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2:22 P.M.</u> to <u>2:22 P.M.</u> , 19 <u>62</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>2:22 P.M.</u> , 19 <u>62</u> , and that death occurred at <u>2:22 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph R. Govi</u> M.D.				22b. DATE SIGNED <u>23 Jan 62</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH R GOVI, Capt USAF MC</u>				22d. ADDRESS <u>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>			
23d. LOCATION (City, town or county) <u>SUITLAND</u>		(State) <u>MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>WW CHAMBERS Co</u>		25a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>			

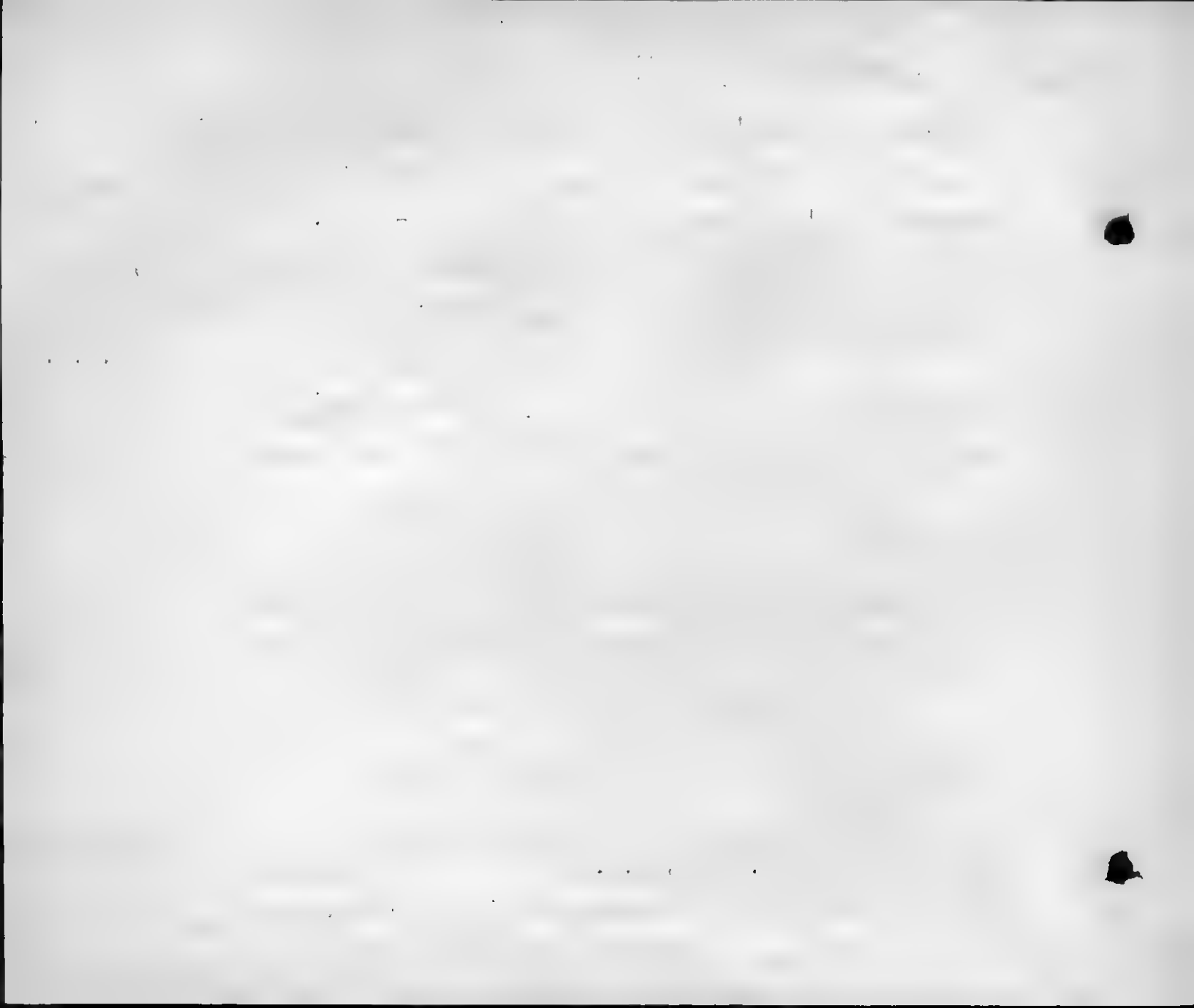
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Charles L. Kneass

2047510.00



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

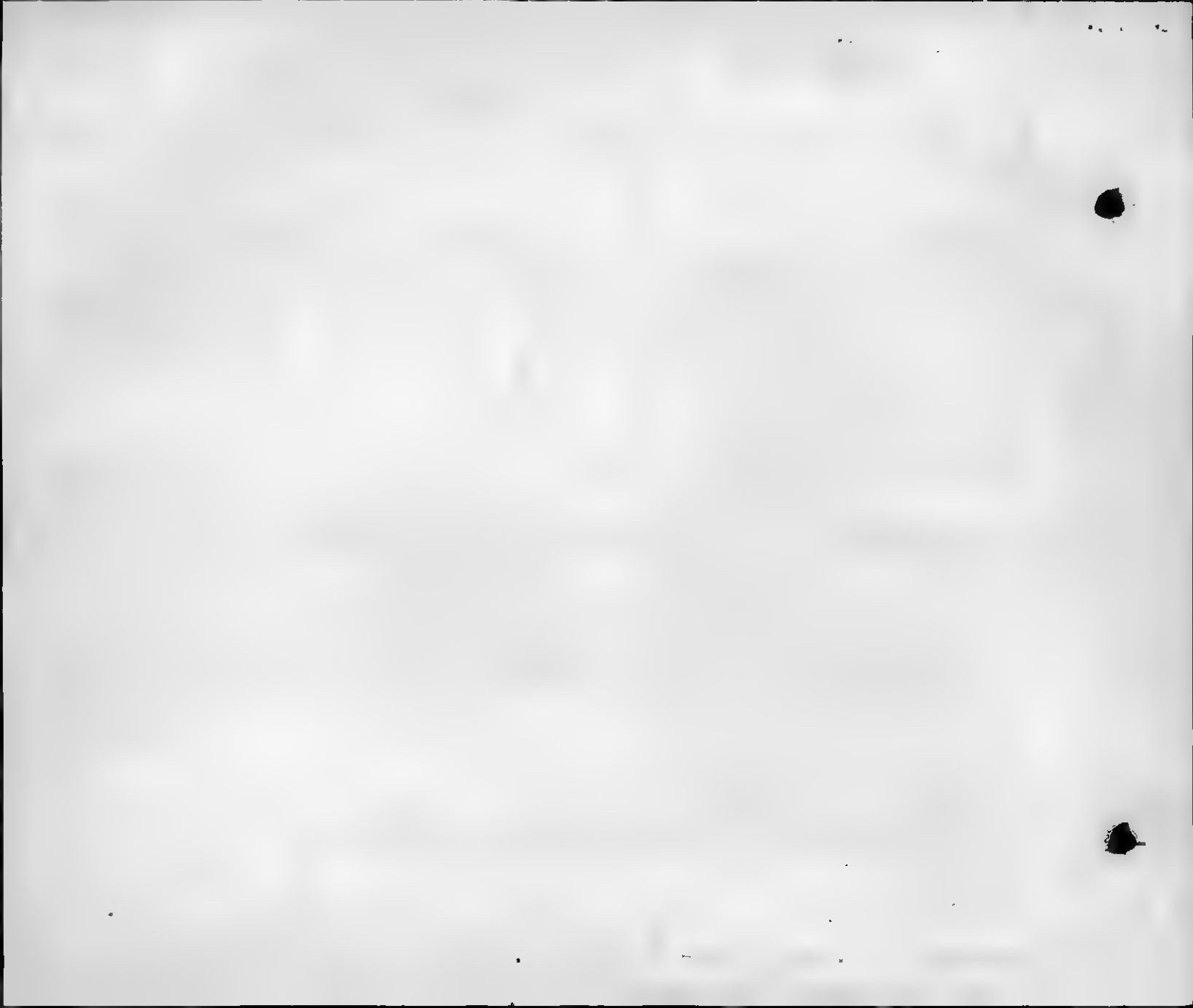
01094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01085

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Prince Georges</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> 42 years</p> <p>c. LENGTH OF STAY IN It</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5120 Forestville Road</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u></p> <p>d. STREET ADDRESS <u>5120 Forestville Road</u></p>			
<p>3. NAME OF DECEASED (Type or print) <u>Lula Estelle Suit</u></p>				<p>4. DATE OF DEATH <u>January 18 1962</u></p>			
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Oct 3, 1890</u></p>	
<p>9. AGE (In years) <u>71</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days</p>		<p>IF UNDER 24 HRS Hours Min.</p>		<p>10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u></p>			
<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>			
<p>13. FATHER'S NAME <u>Charles Hartman</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Mary Estelle Hardesty</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>William Edward Suit, same as #2</u></p>			
<p>17. INFORMANT <u>William Edward Suit, same as #2</u></p>							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Congestive Heart Failure</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u></p> <p>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u></p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				<p>DATE SIGNED <u>January 18, 1962</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>1/21/62</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u></p>		<p>22d. LOCATION (City, town, or country) (State) <u>Forestville Md.</u></p>	
<p>23. FUNERAL DIRECTOR <u>Ritchie Bros. Fun'l Home-</u></p>				<p>24a. REC'D BY REGISTRAR <u>Upper Marlboro Maryland.</u></p>			
<p>24b. REGISTRAR'S SIGNATURE <u>DATE JAN 25 '62</u></p>				<p><u>DATE</u></p>			



CERTIFICATE OF DEATH

Reg. Dist. No.

01088

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST Hgts</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Hillcrest Hgts</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5819- ST. CLAIRE DR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOTTIE E. SULLIVAN</u>				4. DATE OF DEATH Month Day Year <u>JAN 20 1962</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31-1888</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John Keith Lay</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Peake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>William Sullivan 5819- St. Claire Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Block</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1919</u> 19 to <u>Jan 20, 1962</u> that I last saw the deceased alive on <u>Jan 15, 1962</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>20- Mississippi Ave SE Wash. DC</u> DATE SIGNED <u>1-20-62</u>							
ACTUAL SIGNATURE <u>Eugene J. Yorkof</u> M.D. <u>20- Mississippi Ave SE</u>				PHYSICIAN'S NAME (Type) <u>EUGENE J. YORKOF MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Jan. 23-62</u>		<u>Cedar Hill</u>		<u>Southland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ammons Bros.</u> ADDRESS <u>1661- Good Hope Rd SE Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. 8 Fraser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



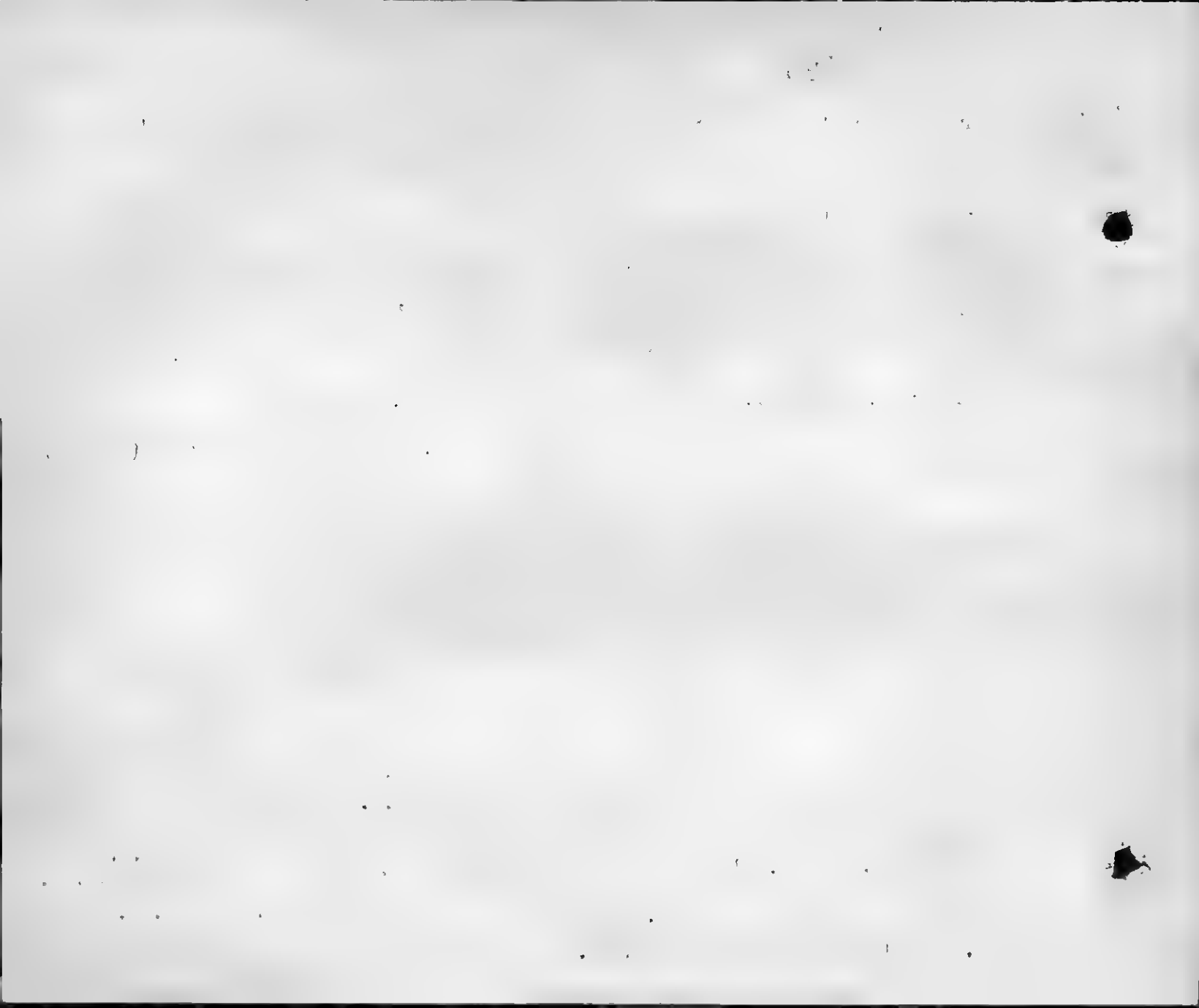
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01096 CERTIFICATE OF DEATH 01087

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill d. STREET ADDRESS 4223 Silver Hill Road		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daniel E. Thom		4. DATE OF DEATH January 11 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 9, 1962	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Herbert A. Thom Jr.		14. MOTHER'S MAIDEN NAME Zietta M. Shriver		12. CITIZEN OF WHAT COUNTRY? U. S. A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Herbert A. Thom Jr Same as #2 (Father)	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hyaline Membrane Disease (c) Prematurity					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-9-62 to 1-11-1962, and that death occurred at 10:05 from the causes and on the date stated above.					
22a. SIGNATURE Dr. John P. D'Angelo		ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4223 Silver Hill Rd S.E. Washington, D.C.		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 15 '62	
				25b. REGISTRAR'S SIGNATURE Arthur E. Hanks	

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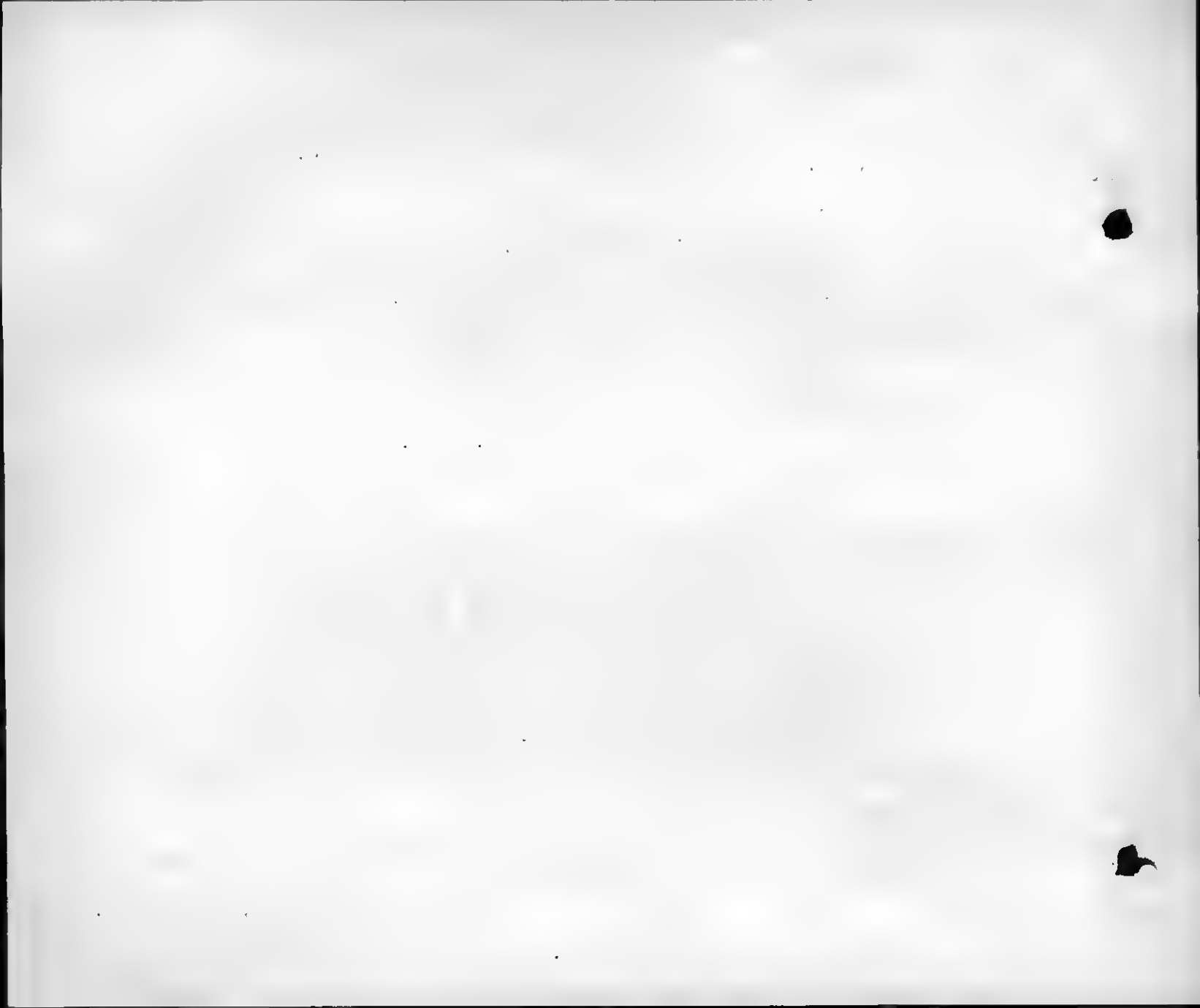


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01097
CERTIFICATE OF DEATH

01088

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Hyattsville, Md.	
c. LENGTH OF STAY IN 1b 7 years		d. STREET ADDRESS 1 3121 Madison Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3121 Madison Street,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Patterson Last Thomas		4. DATE OF DEATH Month Jan Day 19 Year 19 62	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 18, 1871
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Turnbull		14. MOTHER'S MAIDEN NAME Christine Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. none	
17. INFORMANT David T. Thomas same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart failure 4 50.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Arteriosclerosis Heart Enlarged DUE TO (c) ... PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ... INTERVAL BETWEEN ONSET AND DEATH 2 days 15 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1946 to 19 Jan 1962, that (I) (we) lost the deceased alive on 19 Jan 1962 and that death occurred at 4:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE H. B. Queen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. B. QUEEN		22d. ADDRESS 7112 Willow Ave TAKOMA PARK Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/62	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE JAN 22 '62	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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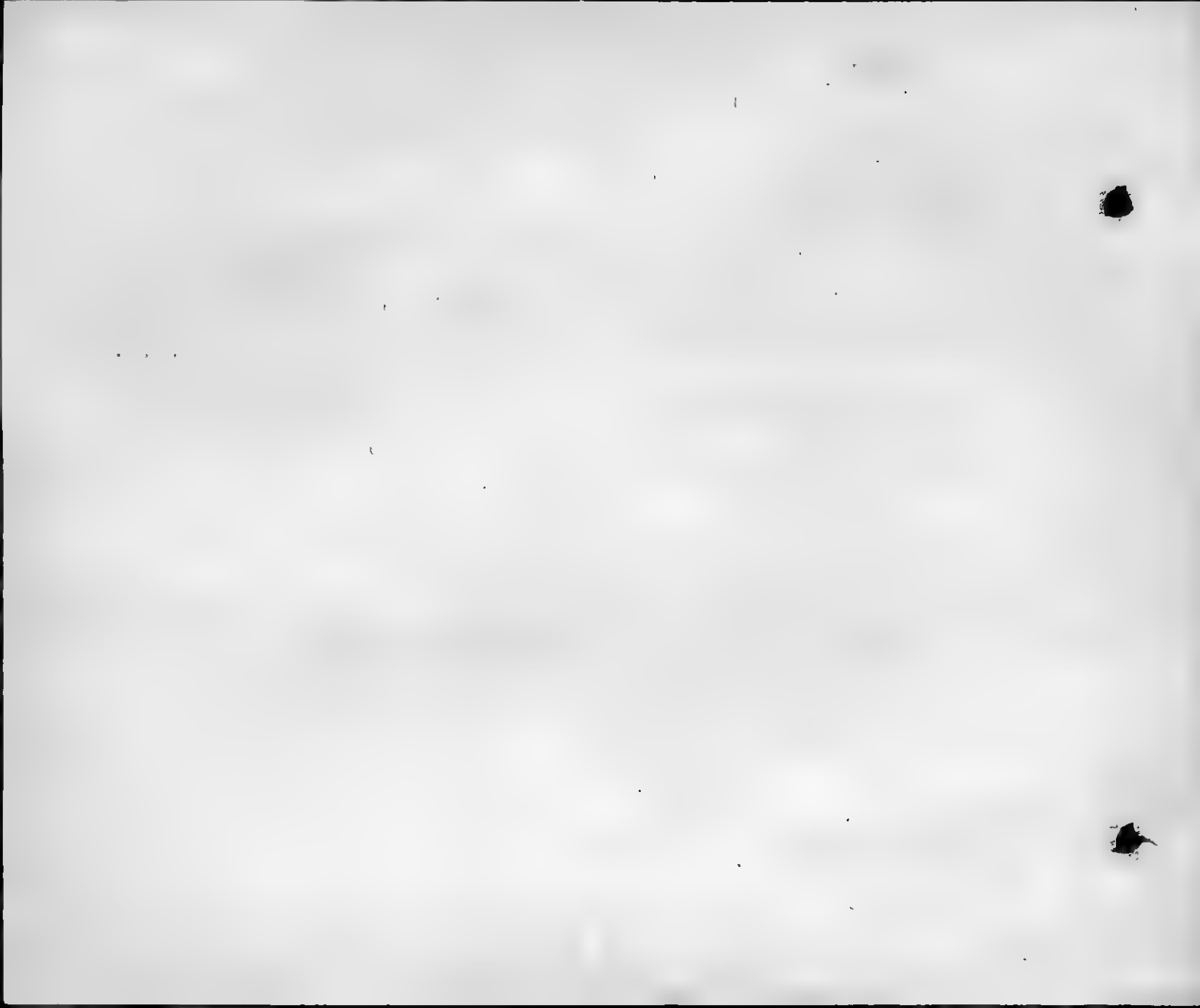
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01098

01089

1. PLACE OF DEATH e. COUNTY <u>Prince George's</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7224 Fort Foote Road</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>			
f. STREET ADDRESS <u>7224 Fort Foote Road</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur Edward Turgeon</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 19, 1907</u>	
9. AGE (In years last birthday) <u>54</u>		IF UNDER 1 YEAR Months <u>54</u> Days <u>54</u>		IF UNDER 24 HRS. Hours <u>54</u> Min. <u>54</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurateur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Turgeon</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Appleyard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)			
17. INFORMANT <u>Wanda Turgeon, same as # 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 4 42 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) DUE TO cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes of twenty years XXXXXXXX duration</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/15/62</u>							
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>James I. Boyd</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 18-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or country) (State) <u>Lutland Md</u>	
23. FUNERAL DIRECTOR <u>Ammons Bros.</u>		ADDRESS <u>1661- Good Hope Rd SE</u>		24a. REC'D BY REGISTRAR <u>WASH. 20 DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

"CORRECTED COPY"

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01099

01090

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 22, D.C. d. STREET ADDRESS 7150 TEMPLE HILL ROAD SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERALD BURTON		4. DATE OF DEATH VICTORIAN II 5 JANUARY 1962		5. 6. 7. 8. 9. 10. 11. 12.	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME GERALD BURTON VICTORIAN		14. MOTHER'S MAIDEN NAME NORA G ROBERTS		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LOBAR, N.E.C., RIGHT MIDDLE AND LEFT LOWER LOBES, ORGANISM UNDETERMINED 783.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 JANUARY, 1962 to 6 JANUARY, 1962 , that (I) (we) last saw the deceased alive on 6 JANUARY, 1962 and that death occurred at 1140 P , from the causes and on the date stated above.					
22a. SIGNATURE John A Moore		22b. DATE SIGNED 5 JAN 15 '62		22c. PHYSICIAN'S NAME (Type) JOHN A MOORE, Major USAF MC	
22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD		22e. REC'D BY REGISTRAR 5 JAN 15 '62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Unburied		23b. DATE THEREOF 1-12-62		23c. NAME OF CEMETERY OR CREMATORY Washington 22, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		24b. ADDRESS 517-11th St. SE Wash D.C.		24c. REGISTRAR'S SIGNATURE William S. Hanna	

20503121

TW FOR ONE CERTIFICATE
FIRM 6-3-5-1/5/2. 70x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01100

01091

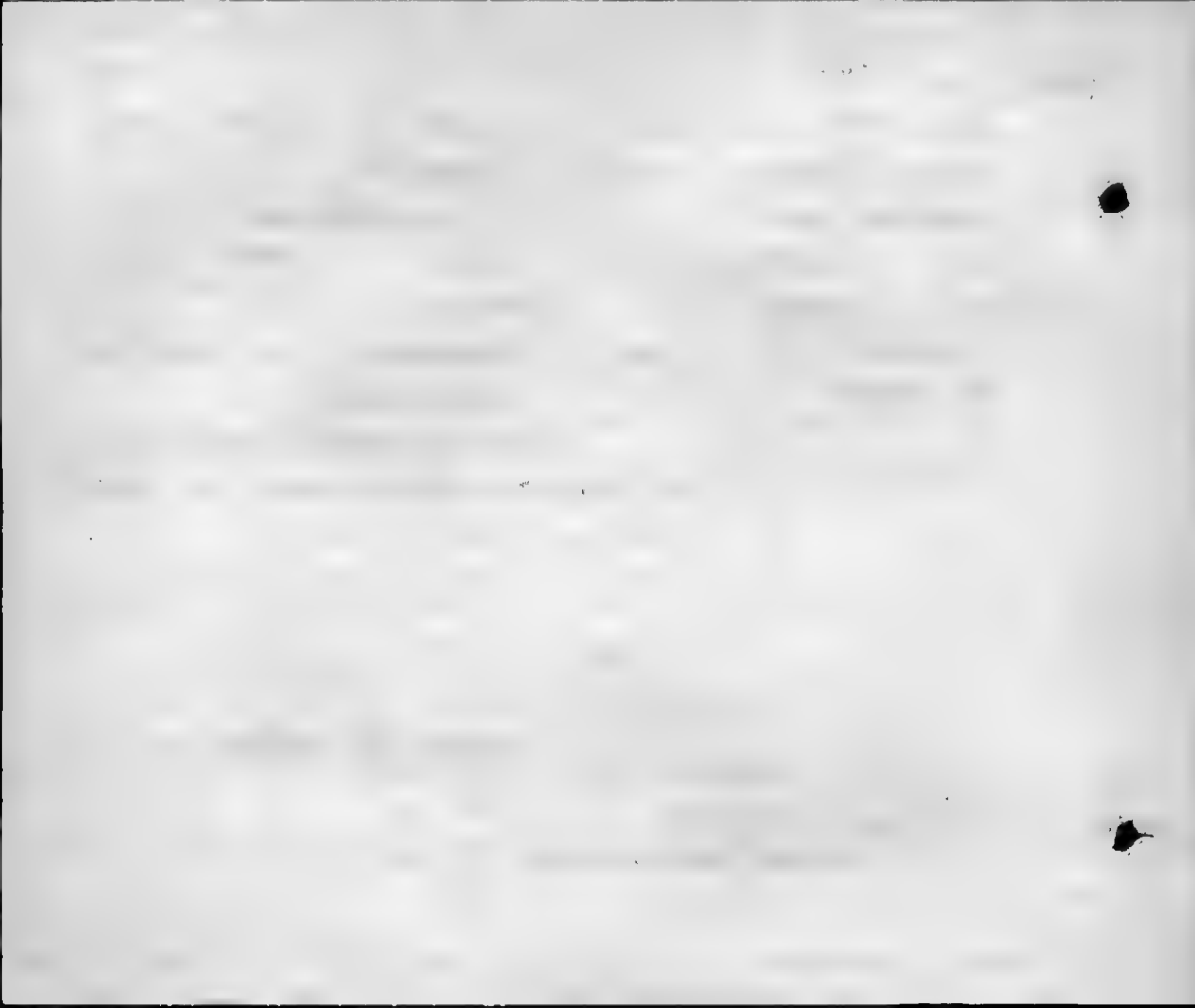
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 7800 LIVINGSTON ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICIA Middle WOLCOTT Last WARD		4. DATE OF DEATH Month JANUARY Day 22 Year 19 62	
5. SEX FEMALE 6. COLOR OR RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 MARCH 1924 9. AGE (in years last birthday) 37 yrs. IF UNDER 1 YEAR: Months 37 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY: 11 NONE 12. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. BIRTHPLACE (County & State, or foreign country) MASSACHUSETTS 14. MOTHER'S MAIDEN NAME LILLIAN H FARNAM	
13. FATHER'S NAME EDWIN A WOLCOTT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)		16. SOCIAL SECURITY NO. RAYMOND A WARD (HUSBAND) 17. INFORMANT SAME AS ITEM #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular standstill secondary to DUE TO diabetes & renal failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) myo DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10 JANUARY, 19 62 to 22 JANUARY, 19 62 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 22 JANUARY, 19 62 , and that death occurred at 7:35 P M, from the causes and on the date stated above.			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) WILLIAM C B GRAHAM, Capt USAF MC		22b. DATE SIGNED 22 JAN. 62 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 25-62		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Ashtington National		23d. LOCATION (City, town or county) (State) Ashtington Va	
24. FUNERAL DIRECTOR'S SIGNATURE Sammons Bros		25a. REC'D BY REGISTRAR DATA 25 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna		25c. ADDRESS 1661-9d Ave Rd S E Wash DC	

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01101

01092

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE 2 HRS 19 MIN c. LENGTH OF STAY IN 1b 2 HRS 19 MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 1322 SAVANNAH STREET SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN HUGH WATLINGTON		4. DATE OF DEATH JANUARY 28 19 62	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JANUARY 1962
9. AGE (In years last birthday) 28		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME THOMAS B WATLINGTON		14. MOTHER'S MAIDEN NAME EDNA A BUTSCHK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEDICAL RECORDS, USAF HOSPITAL ANDREWS, AFB, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) PULMONARY ATELECTASIS (b) MARKED LARYNGEAL EDEMA (c) PREMATURITY AND IMMATURITY	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. TIME OF INJURY Month Day, Year 19 62 Hour a.m. 1054P p.m. 19	
21. I certify that (I) (XXXXXX) attended the deceased from 28 JANUARY, 19 62 to 28 JANUARY, 19 62 that (I) (XX) last saw the deceased alive on 28 JANUARY 19 62, and that death occurred at 1054P from the causes and on the date stated above.		22. SIGNATURE <i>Arthur D. Hestley</i> MD 22c. PHYSICIAN'S NAME (Type) Capt USAF MC	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY ANDREWS AIR FORCE BASE	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hestley</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

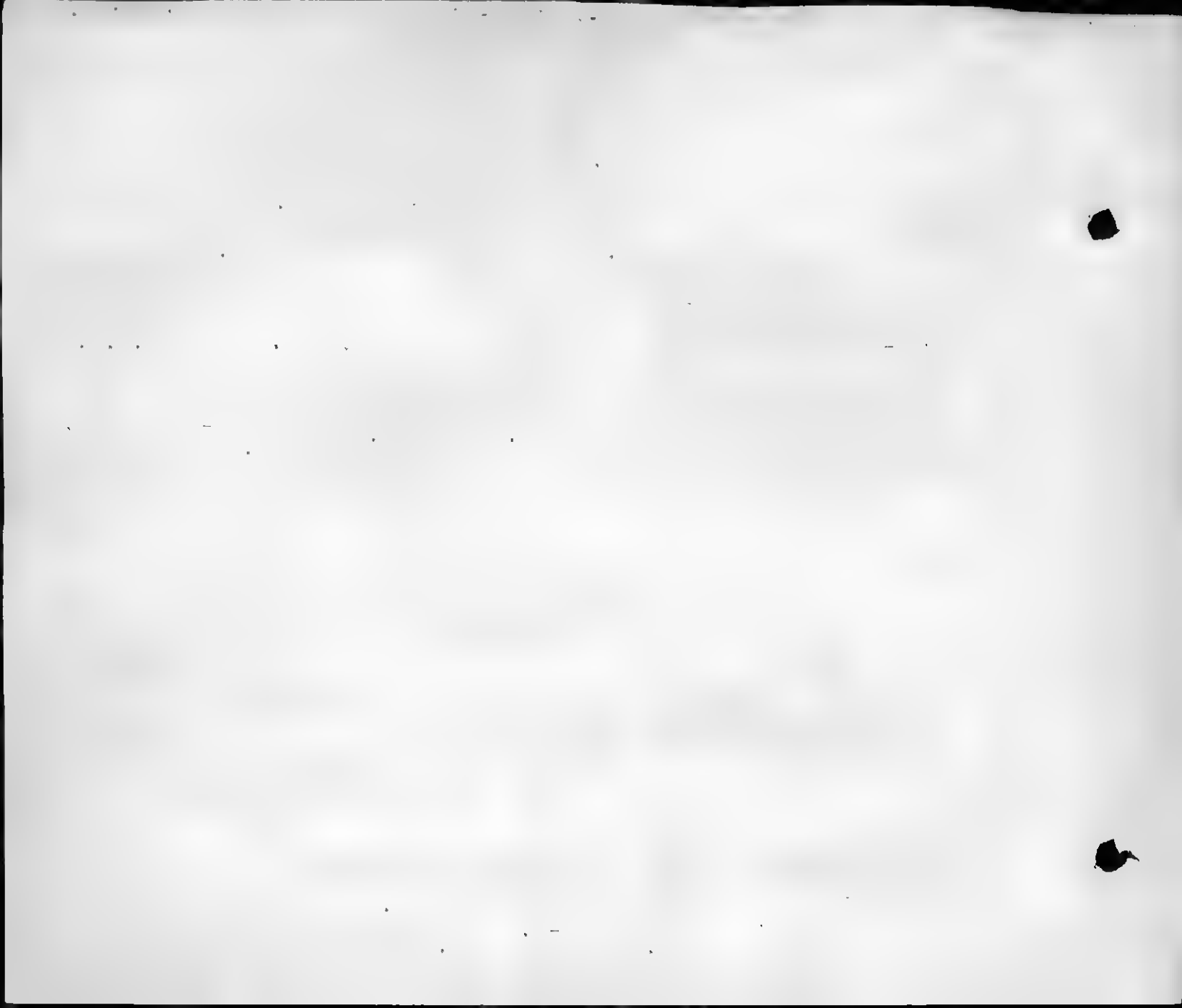
CERTIFICATE OF DEATH

Reg. Dist. No.

01102

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 East Riverdale			
c. LENGTH OF STAY IN TB 2 yrs.				d. STREET ADDRESS 6143 - 64th Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Madison Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ella G. Webster				4. DATE OF DEATH Month Day Year Jan. 6 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/1880	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Retired				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving			
13. FATHER'S NAME William Bartholme				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Estelle E. Gold	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.12X DUE TO CARDIO-VASCULAR-RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) 5 yrs. INTERVAL BETWEEN ONSET AND DEATH 1 yr.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from DEC. 1959, to JAN. 6, 1962, that I last saw the deceased alive on JAN. 4, 1962, and that death occurred at 11:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold F. McCann M.D.				ADDRESS (Street, city or town, state) 3355 - 16th St. N.W. DATE SIGNED 1/7/62			
PHYSICIAN'S NAME (Type) HAROLD F. MCCANN				Washington 10, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1962		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 3200-R.I. Ave., Mt. Rainier, Md.				24a. REC'D BY REGISTRAR DATE JAN 9 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



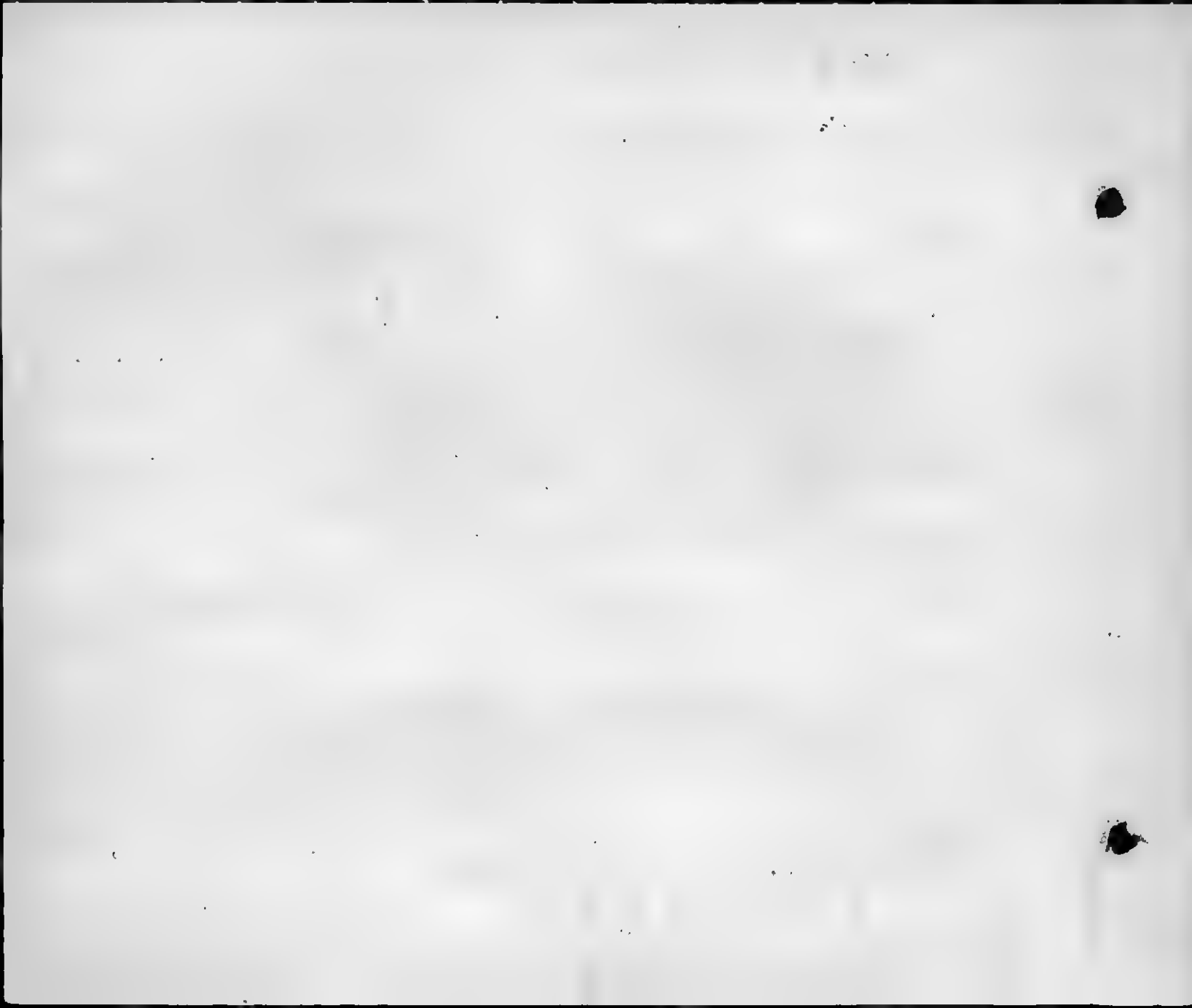
3 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>7 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			d. STREET ADDRESS <u>5140 Flintridge Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Adsacorda Convalence Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Lorraine</u> Last <u>Weedon</u>					4. DATE OF DEATH <u>Jan. 28</u> 19 <u>62</u>				
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 29, 1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Julian M. Weedon</u>		Address <u>Same as #2</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u>									
(c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>James I. Boyd</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <u>January 28, 1962</u>				
					Address (Street, city, town, or county) _____				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 31/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or country) (State) <u>Colonial Beach Va</u>			
23. FUNERAL DIRECTOR <u>Nalley's Funeral Home, Inc.</u> <u>Mt. Rainier, Md.</u>					24a. REC'D BY REGISTRAR <u>JAN 31 '62</u>		24b. REGISTRAR'S SIGNATURE <u>James I. Boyd</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

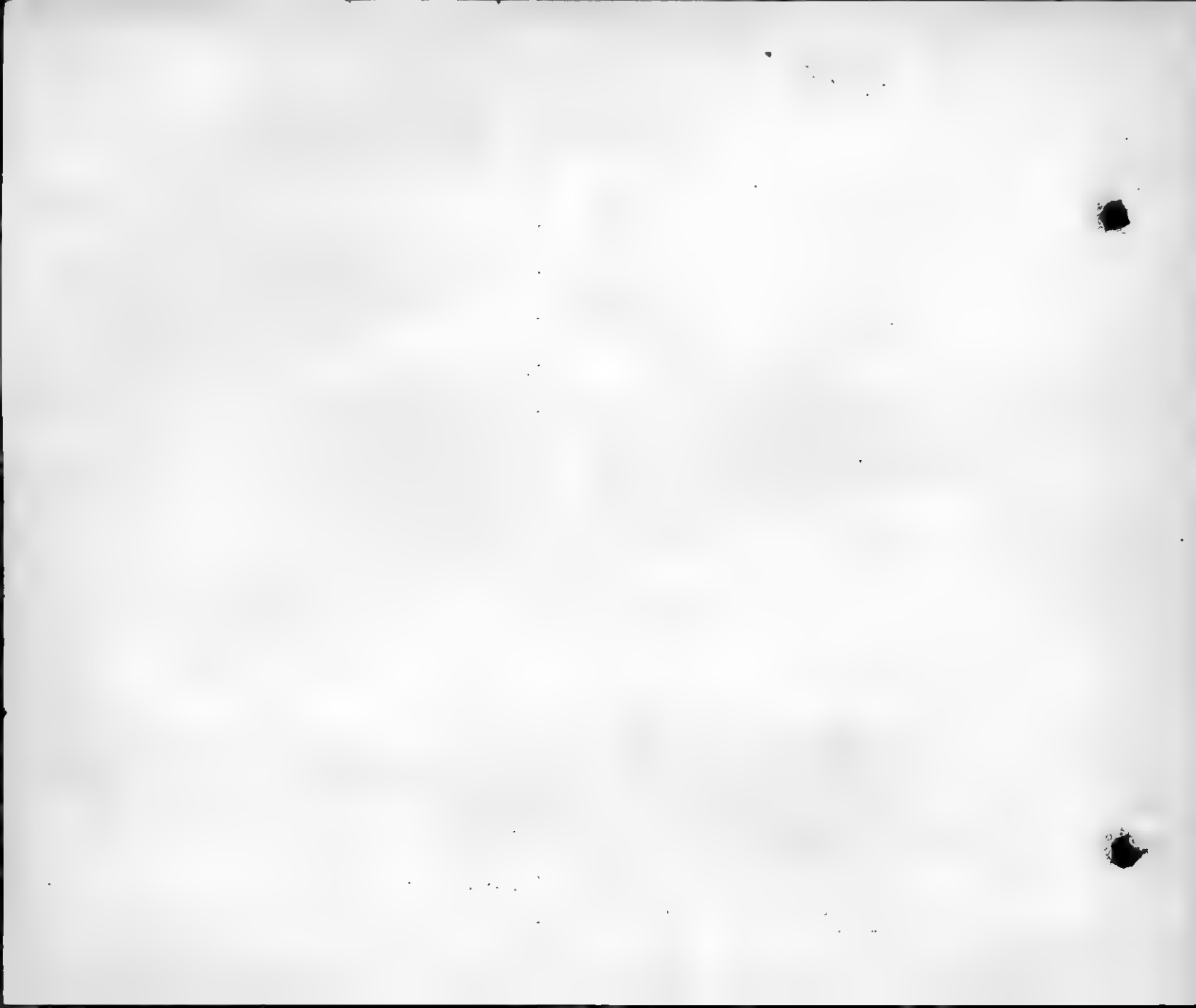
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01104

01095

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>28 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Memorial Hosp</u>				d. STREET ADDRESS <u>1631 Wood St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gustavus</u>		First Middle Last <u>Whitehead</u>		4. DATE OF DEATH Month Day Year <u>Jan 14 1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 1874</u>	9. AGE (In years last birthday) yrs. Months Days <u>87</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gustavus Whitehead</u>				14. MOTHER'S MAIDEN NAME <u>Mary Morrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Retired</u>		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>610X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Nephrosclerosis</u> <u>Hypertrophy of Prostate Gland & Obstruction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>1950</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , to <u>Jan 14 1962</u> , that (I) <u>last</u> saw the deceased alive on <u>Jan 14 1962</u> , and that death occurred <u>5:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan 14 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>				22d. ADDRESS <u>Laurel Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/16/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Davidson</u>				25a. RECEIVED BY REGISTRAR DATE <u>JAN 18 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

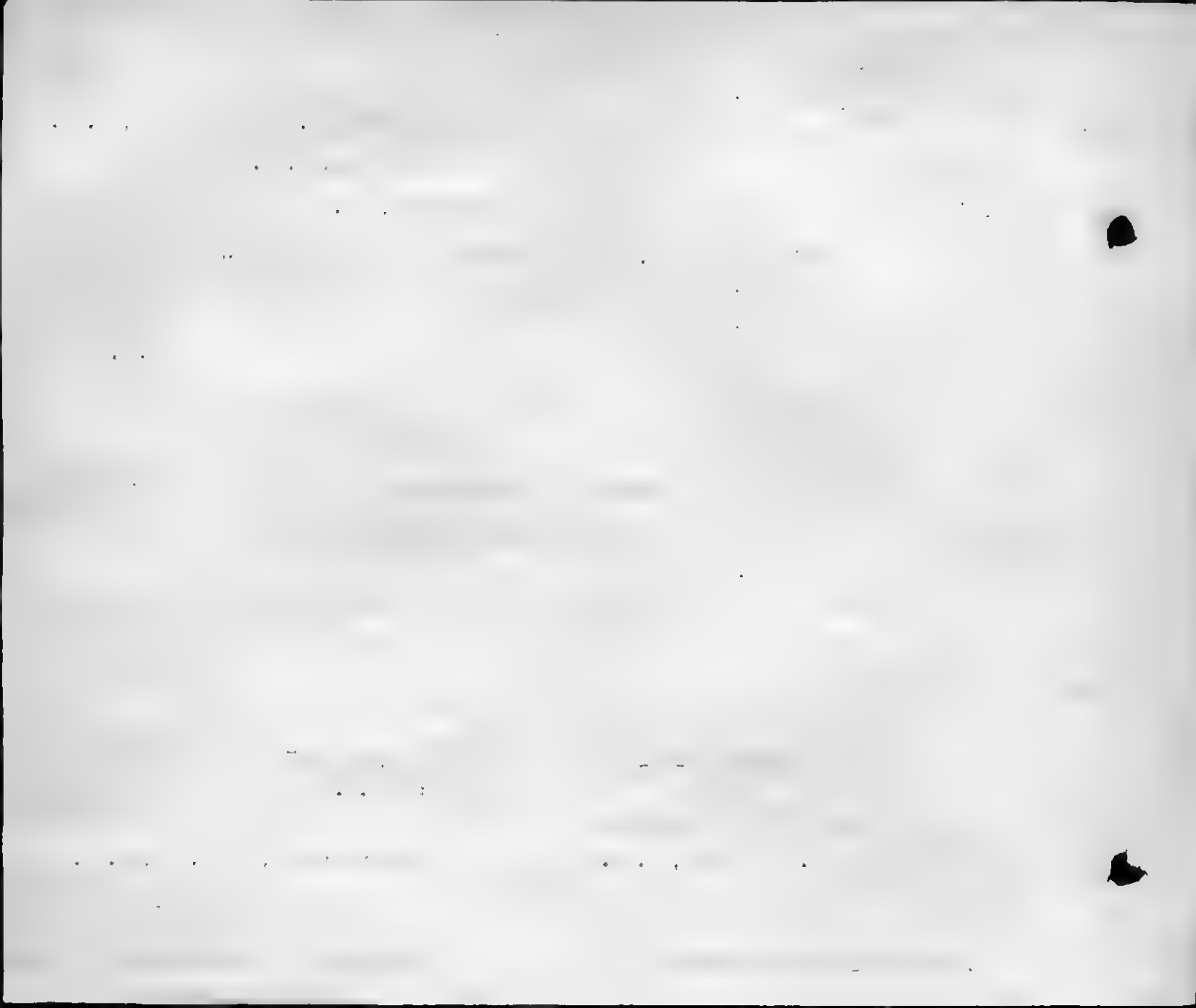


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01105											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Since 1/13/62 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Pr. George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 28, D. C. d. STREET ADDRESS Cheverly, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sadie H. Whitney						4. DATE OF DEATH Month Day Year January 26 1962					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/13/78		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Whitney						14. MOTHER'S MAIDEN NAME Merinda Moyer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give number or date of service) none		17. INFORMANT Miss Bess Whitney - sister				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic heart disease DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1/13/62 to 1-26-1962, that (I) (we) last saw the deceased alive on 1-26-1962, and that death occurred at 1:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Angus W. Mc Laurin, M. D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/26/62			
22c. PHYSICIAN'S NAME (Type) Angus W. Mc Laurin, M. D.						22d. ADDRESS 4637 Eastern Avenue, Wash. 18, D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-29-62		23c. NAME OF CEMETERY OR CREMATORY Laceyville		23d. LOCATION (City, town or county) Baceyville, Pa. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees, Wash. D.C.						25a. REC'D BY REGISTRAR DATE JAN 29 '62		25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

(M)

44

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01106 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01097											
1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton				c. LENGTH OF STAY IN b 15 minutes				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywind			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Southern Maryland Medical Center				d. STREET ADDRESS Box 384 Route # 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Ray Willett				4. DATE OF DEATH Month January Day 16 Year 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1916		9. AGE (in years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Willett				14. MOTHER'S MAIDEN NAME Florence Hibbert							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 706-07-7603		17. INFORMANT Evelyn Sievert, 4626 Lacey Avenue, Suitland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hepatic failure DUE TO (c) Cirrhosis of the liver								INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/16/62			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1-19-62		22c. NAME OF CEMETERY OR CREMATORY IMMANUEL METH.		22d. LOCATION (City, town, or country) BADEN, MARYLAND			
23. FUNERAL DIRECTOR The HUNT FUNERAL HOME, WALDORF, MD.				ADDRESS 		24a. REC'D BY REGISTRAR DAJAN 22 '62		24b. REGISTRAR'S SIGNATURE Int. S. Evans			

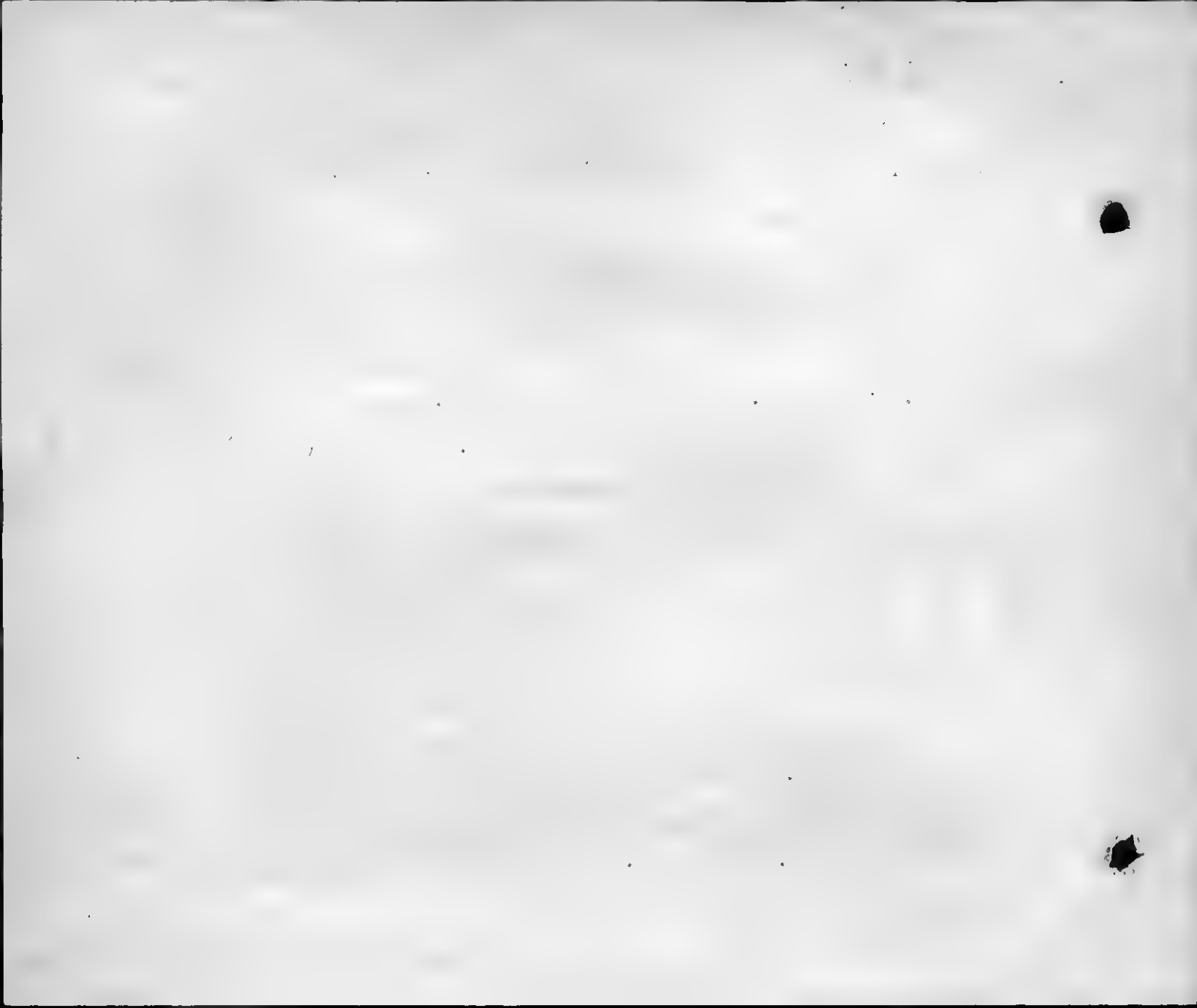
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01107		Item 22a,b,c,d		Film G306		1/31/62		iwk		01095	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY in lb 22 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 24 HYATTSVILLE d. STREET ADDRESS 7316 84th AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) DARIN RODNEY WILLIAMS				4. DATE OF DEATH Month JANUARY Day 24 Year 19 62							
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 JANUARY 1962		9. AGE (In years last birthday) yrs. 22		IF UNDER 1 YEAR Months 22 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME SAMUAL G. WILLIAMS JR.				14. MOTHER'S MAIDEN NAME ROSE M. BUNDY				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) NONE			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT SAMUAL G. WILLIAMS JR(FATHER)				Address SAME AS ITEM #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Erythroblastosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Erythroblastosis DUE TO (c) Erythroblastosis								INTERVAL BETWEEN ONSET AND DEATH 22 HRS 27 MIN 22 HRS 27 MIN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from 23 JANUARY, 19 62 to 24 JANUARY 19 62 , that (I) (he) last saw the deceased alive on 24 JANUARY 19 62 , and that death occurred at 515AM , from the causes and on the date stated above.											
22a. SIGNATURE Arnold G. Brody				22b. DATE SIGNED 24 JANUARY 1962				22c. PHYSICIAN'S NAME (Type) ARNOLD G. BRODY, CAPT., USAF MC			
22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue (Washington)		23d. LOCATION (City, town or county) 19 and E Streets, S.E.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				25a. REC'D BY REGISTRAR JAN 26 '62		25b. REGISTRAR'S SIGNATURE John L. Thomas	

206-516



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
1108			
1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Georgia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Augusta	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 1221 B Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR Carlous Williams		4. DATE OF DEATH Month January Day 15 Year 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-95	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY LUMBER MILL	
11. BIRTHPLACE (Country & State, or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW WILLIAMS		14. MOTHER'S MAIDEN NAME LIZZIE TODD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 258-26-0518	
17. INFORMANT MRS ALTON ROGERS		Address 2806 5th Ave Dillon Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 30 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 1-14 , 1962, to 1-15 , 1962, that (I) (we) last saw the deceased alive on 1-15 , 1962, and that death occurred at 3:20 , from the causes and on the date stated above.			
22a. SIGNATURE R.D. Bauer		22b. DATE SIGNED 1-25-62	
22c. PHYSICIAN'S NAME (Type) R.D. BAUER, M.D.		22d. ADDRESS Prince Georges Hospital, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 18-1962	
23c. NAME OF CEMETERY OR CREMATORY HILL CREST MEM PARK		23d. LOCATION (City, town or county) (State) AUGUSTA, GEORGIA	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. Riverdale, Md.		25a. REC'D BY REGISTRAR JAN 18 '62	
25b. REGISTRAR'S SIGNATURE William S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01109

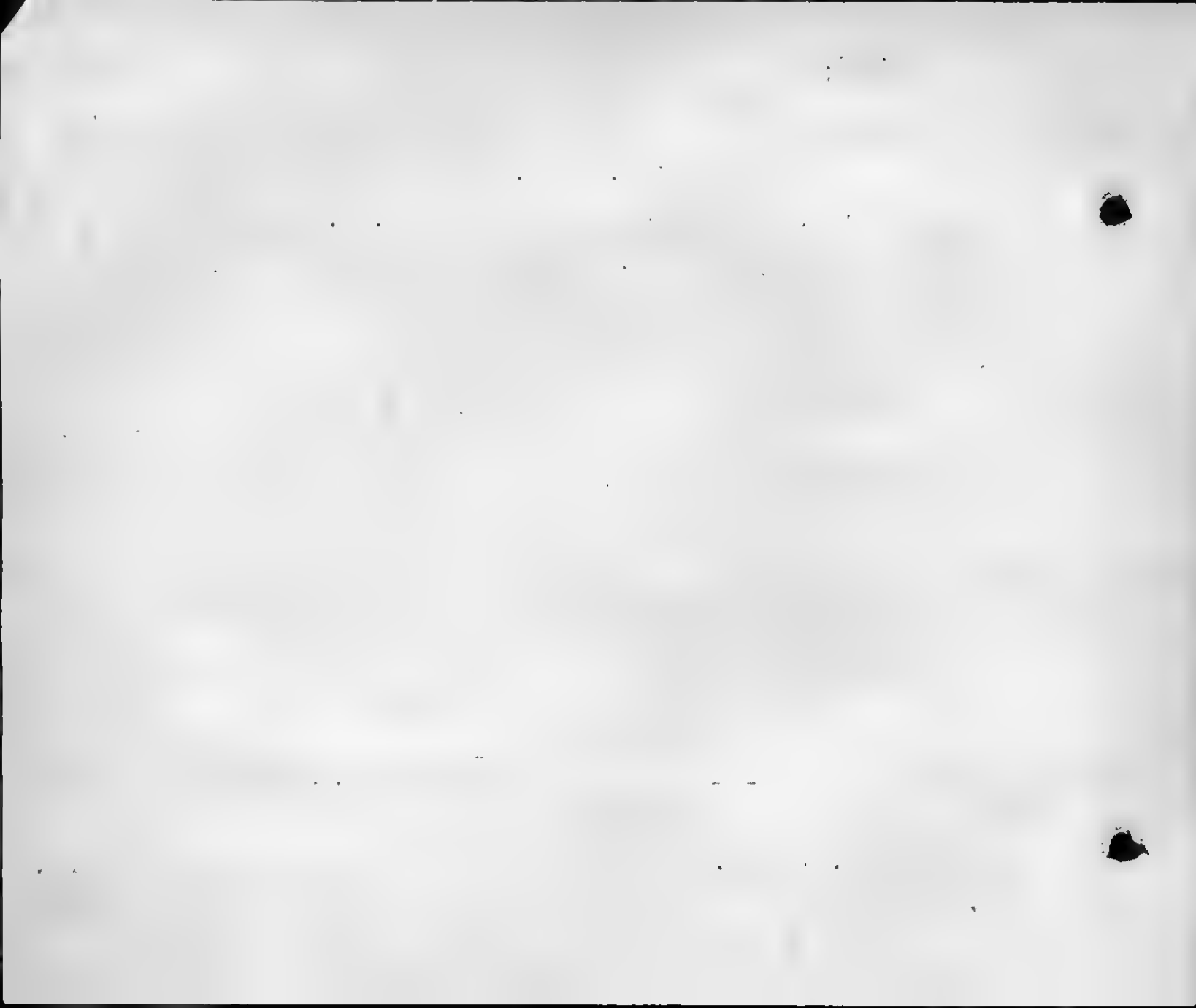
CERTIFICATE OF DEATH

01100

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 Hr. 40 Min. Riverdale</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>6205 - 43rd. St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>B.</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 18, 1875</u> 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Robert W. Wilson</u> Address <u>7411 Hyndale Rd. Chevy Chase, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary thrombosis</u> (b) <u>Coronary artery atherosclerosis</u> (c) <u>Coronary artery atherosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-21-62</u> , 19 <u>62</u> , to <u>1-21-62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-21-62</u> , 19 <u>62</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald C. Edgren</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-22-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Donald C. Edgren</u>				22d. ADDRESS <u>Prince George's Plaza, Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum, Beltsville, Md.</u>		23d. LOCATION (City, town or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co.</u>				25a. REC'D BY REGISTRAR <u>5801 Cleveland Ave. Riverdale, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Clarence S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

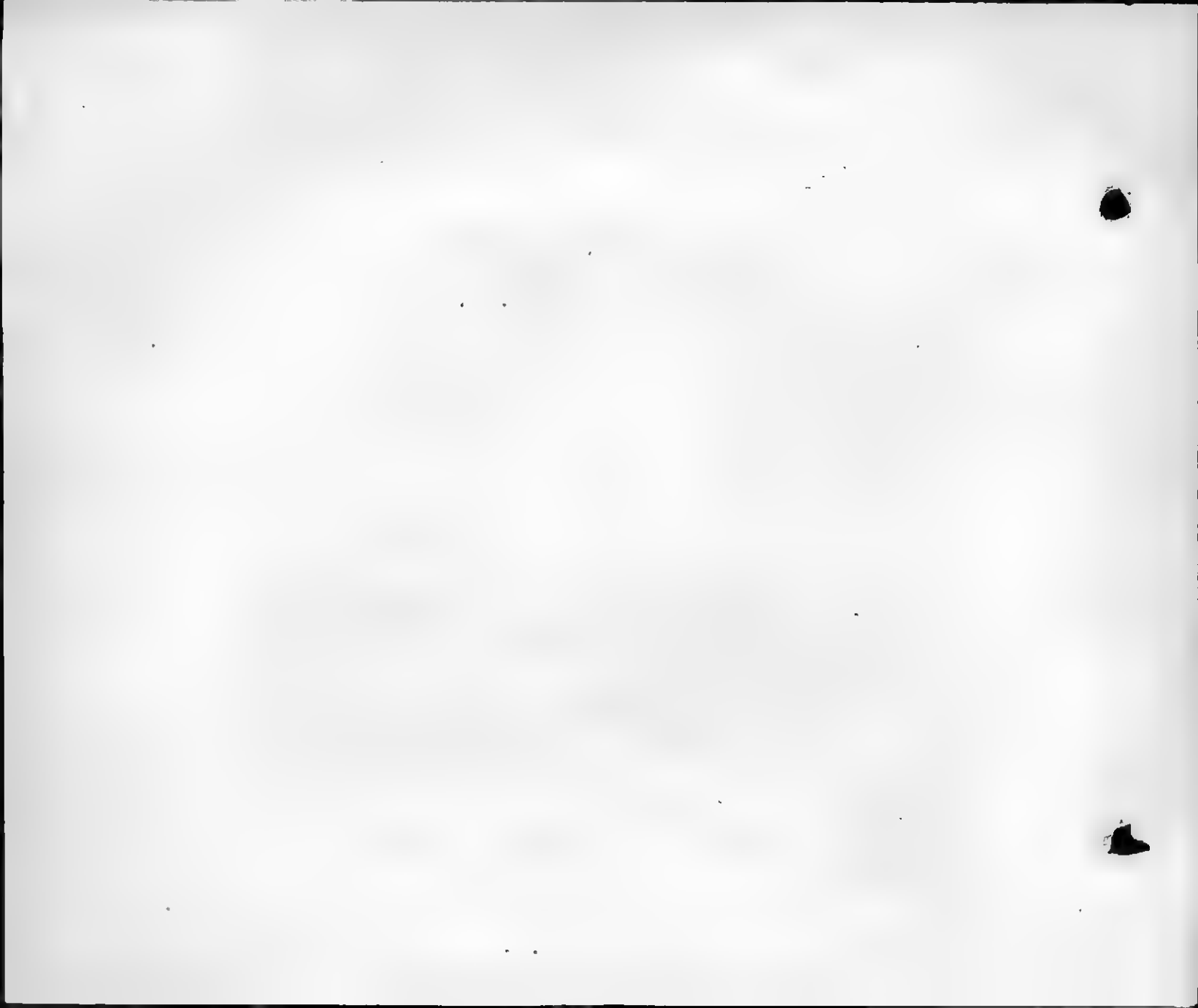
CERTIFICATE OF DEATH

011110

011110

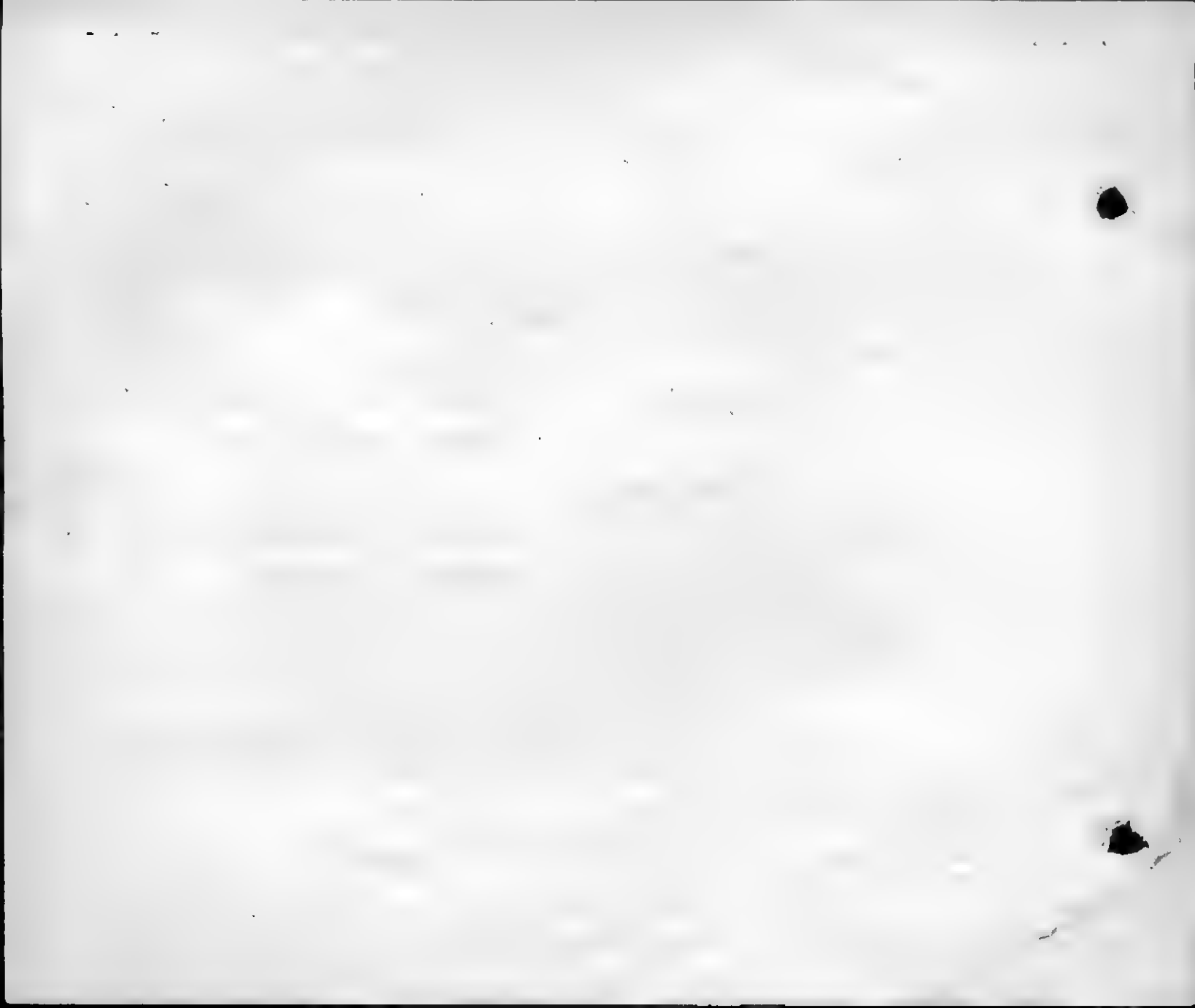
1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville				c. LENGTH OF STAY IN 1b X Forestville			
d. NAME OF HOSPITAL (If not in hospital, give street address) 6212 Barry Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IRENE First L. Middle WILSON Last				4. DATE OF DEATH Month January Day 6 , Year 1962			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1887	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months 74 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Telegraph		11. BIRTHPLACE (State or foreign country) Wash D.C.		12. CITIZEN OF WHAT COUNTRY? D.C.	
13. FATHER'S NAME Thomas Raussillon				14. MOTHER'S MAIDEN NAME Marie Salambo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 579-05-1694		17. INFORMANT Miss Ethel Wilson			Address same as above.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, left kidney 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland, Md. (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 12-28-1961 to 1-6-1962 that (I) (we) last saw the deceased alive on 1-5-1962 and that death occurred at 4:30 PM , from the causes and on the date stated above.							
22a SIGNATURE Thomas F. Cleary				22b ADDRESS 5532 Silver #11 Rd SE Wash 28 D.C.			
22c PHYSICIAN'S NAME (Type) Thomas F. Cleary, MD.				22d ADDRESS 5532 Silver #11 Rd SE Wash 28 D.C.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 1-9-62		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d LOCATION (City, town, or county) Suitland, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.				25a REC'D BY REGISTRAR DATE JAN 9 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 on would be filed with the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

011111		011162	
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville (Rural)</u>	
c. LENGTH OF STAY IN lb <u>2 mos</u>		d. STREET ADDRESS <u>1 Mitchellville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8915 Glenarden Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sylvester</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20-1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillip Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Norman Wilson</u>	
17. INFORMANT Address <u>Norman Wilson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 mos</u> <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 7, 1961</u> to <u>Jan 4, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 4, 1962</u> and that death occurred at <u>7 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry A. Wise Jr.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>		22d. ADDRESS <u>9005 Volta St, Lanham Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>148-62</u>		23b. DATE THEREOF <u>148-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		23d. LOCATION (City, town, or county) (State) <u>Woodmore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amys Washington + Son</u> ADDRESS <u>4925 Adams Ave NE</u>		25a. REC'D BY REGISTRAR DATE <u>11 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>2</u>	



FOR STATE
HEALTH DEPT.

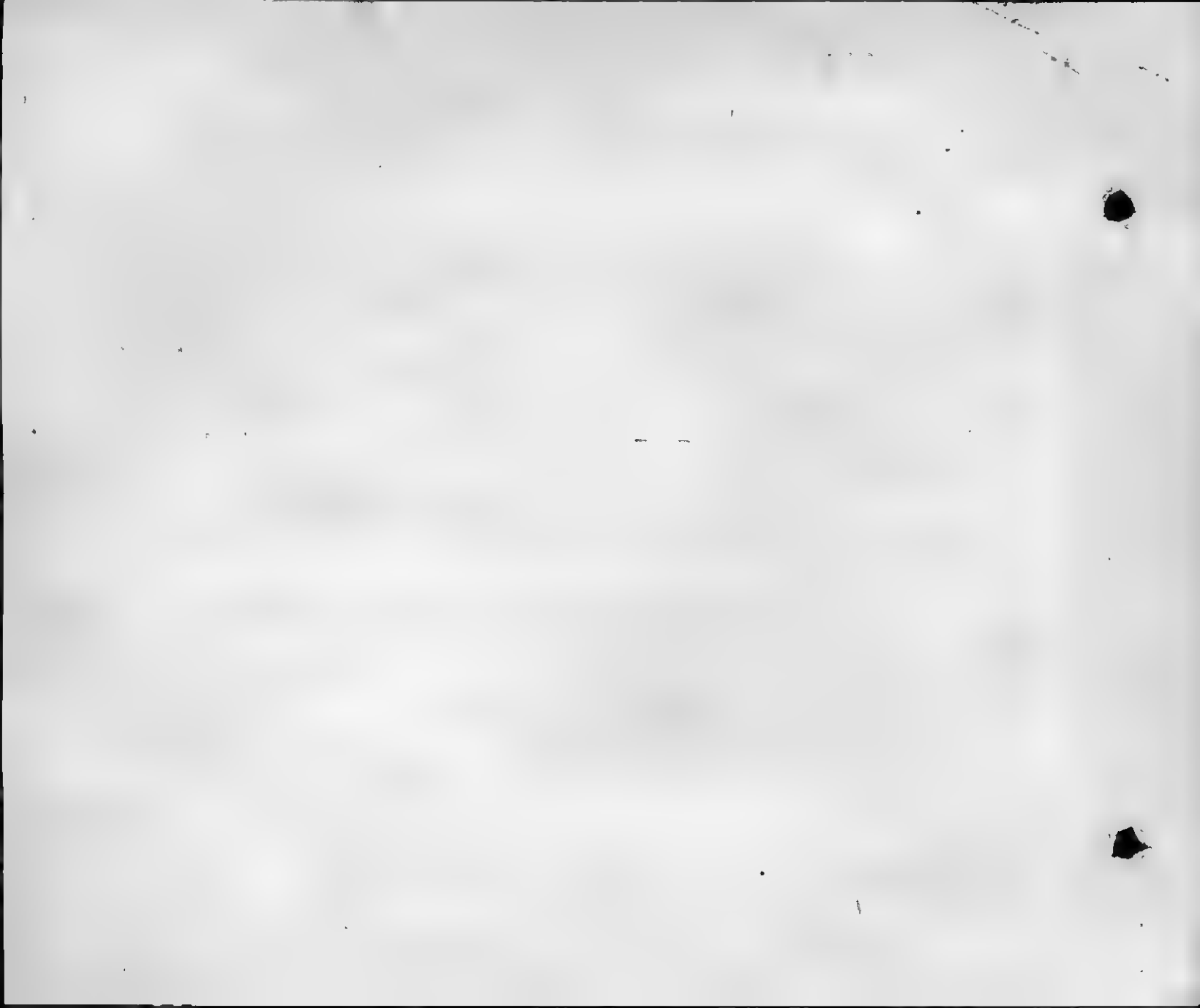
TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cederville		c. LENGTH OF STAY IN TB 4 years	
3. NAME OF DECEASED (Type or print) Raymond Benjamin Winston		4. DATE OF DEATH Month January Day 13 Year 1962		5. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin Winston		14. MOTHER'S MAIDEN NAME Mary Nichols		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Unknown		16. SOCIAL SECURITY NO. 577-28-0210		17. INFORMANT Malcolm Benjamin Winston, Trappe, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 14, 1962	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-19-63		22c. NAME OF CEMETERY OR CREMATORY Streamerville	
22d. LOCATION (City, town, or country) Oxford Md.		24a. REC'D BY REGISTRAR James B. Ashfield - Faston, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

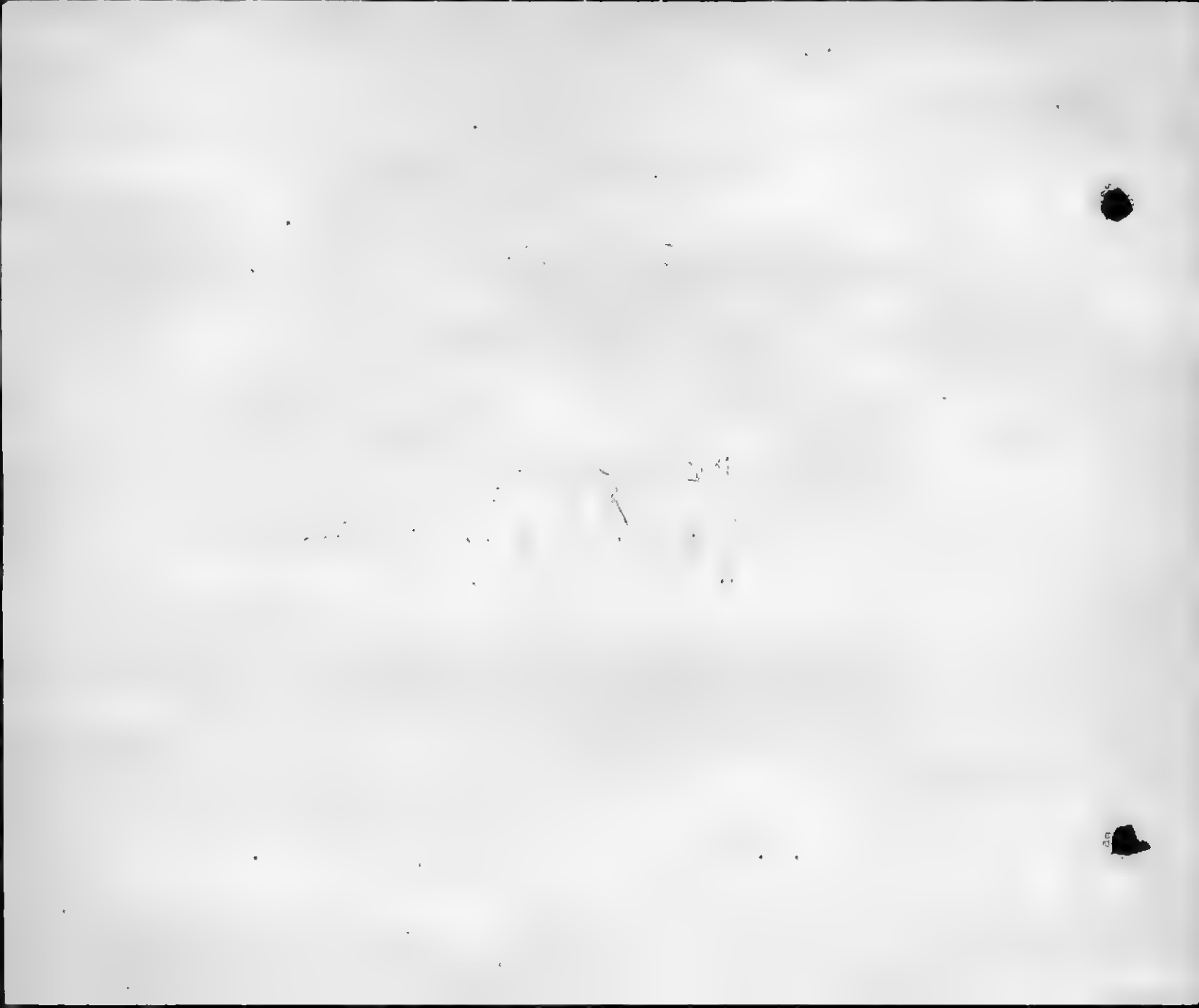
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011113

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

011113

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b. <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>8154 Burnside Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Catharine P. Woodham</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 15 1879</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FLORIDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STEELE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. LILLIE MAE SHANKS</u>				Address <u>SAME AS 2C + D</u>			
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>44.1</u> DUE TO <u>Arteriosclerosis Heart Diseases</u> Conditions, if any, which gave rise to immediate cause (b) <u>Nephrosclerosis</u> (c) <u>ENCEPHALITIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5, 1962</u> to <u>1/7, 1962</u> that (I) (we) last saw the deceased alive on <u>1/6, 1962</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. C. James Duke</u>				22b. DATE SIGNED <u>4/7/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. James Duke</u>				22d. ADDRESS <u>6607 Riverdale Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 10, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OPP CITY CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>OPP ALABAMA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>				25. REC'D BY REGISTRAR <u>JAN 9 '62</u>			
ADDRESS <u>RIVERDALE, MD.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>			

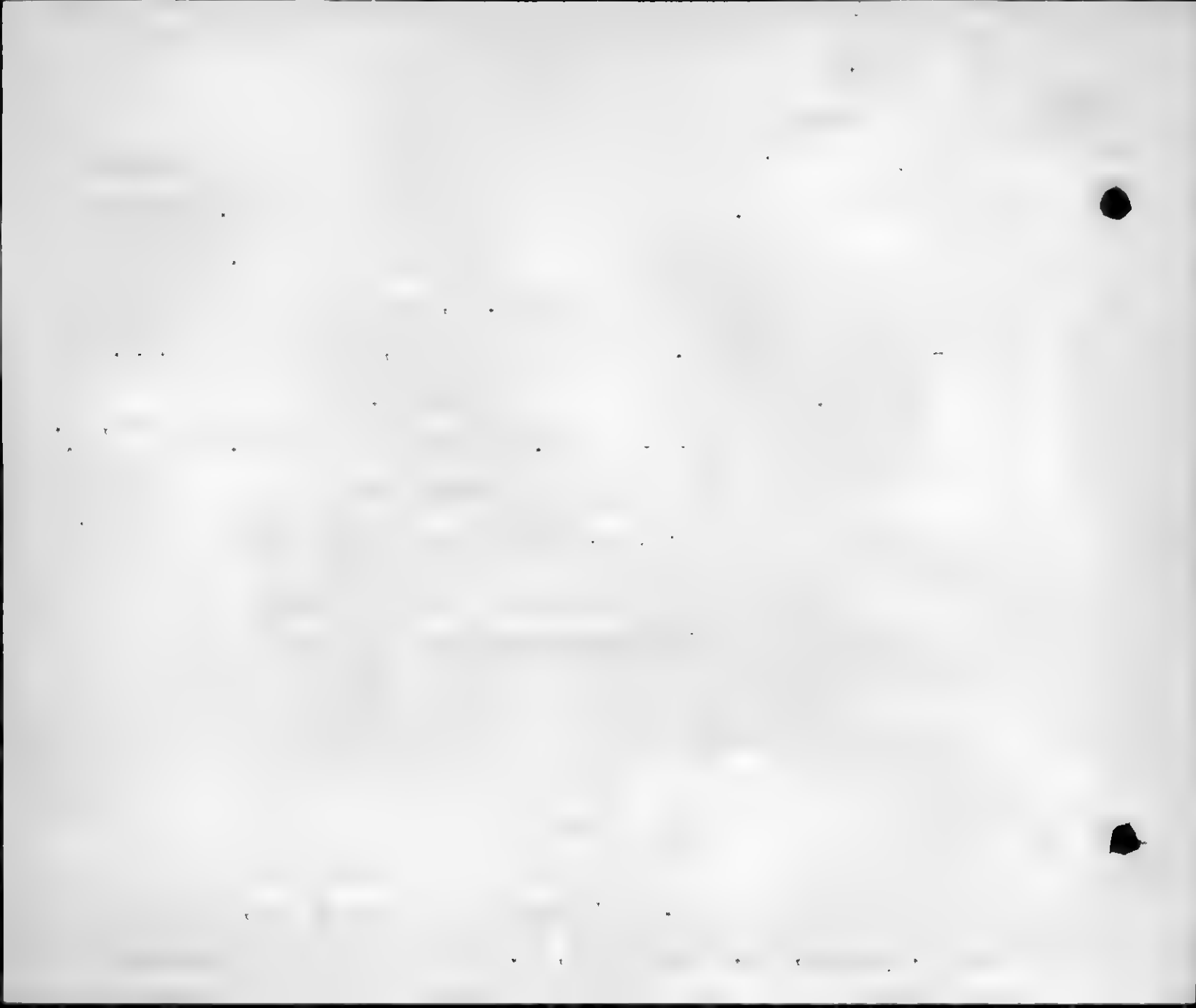


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George's</u> MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>53 Takoma Park</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7105 New Hampshire Ave.</u>												d. STREET ADDRESS <u>7105 New Hampshire Ave.</u>											
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Theresa</u> Last <u>Yates</u>												4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>19 62</u>											
5. SEX <u>female</u>												6. COLOR OR RACE <u>white</u>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>Sept. 15, 1907</u>											
9. AGE (In years last birthday) <u>54</u> yrs.												IF UNDER 1 YEAR Months <u> </u> Days <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk-typist</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Army</u>											
11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Maryland</u>												12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>											
13. FATHER'S NAME <u>Edward M. Wise</u>												14. MOTHER'S MAIDEN NAME <u>Eleanor M. Poore</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>												16. SOCIAL SECURITY NO. <u>579-12-8207</u>											
17. INFORMANT <u>Mr. John Robert Yates</u>												Address <u>Takoma Park, Md. 7105 N. Hampshire Ave.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Diffuse pulmonary metastasis</u> DUE TO (c) <u>Carcinoma of left breast</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>Months</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Wide spread osteoporosis</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>												20f. (City or town) (County) (State) <u> </u>											
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 12, 1962</u> to <u>Jan. 15, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 12, 1962</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>Richard P. DeLaney</u> M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>4323 Harvard St., S.E. 4323</u>											
22c. PHYSICIAN'S NAME (Type) <u>Richard P. DeLaney</u>												22b. DATE SIGNED <u>1/15/62</u>											
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>1-18-62</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>												23d. LOCATION (City, town or county) (State) <u>Forest Glen, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>												25a. REC'D BY REGISTRAR <u>JAN 19 '62</u>											
ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>												25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hump</u>											



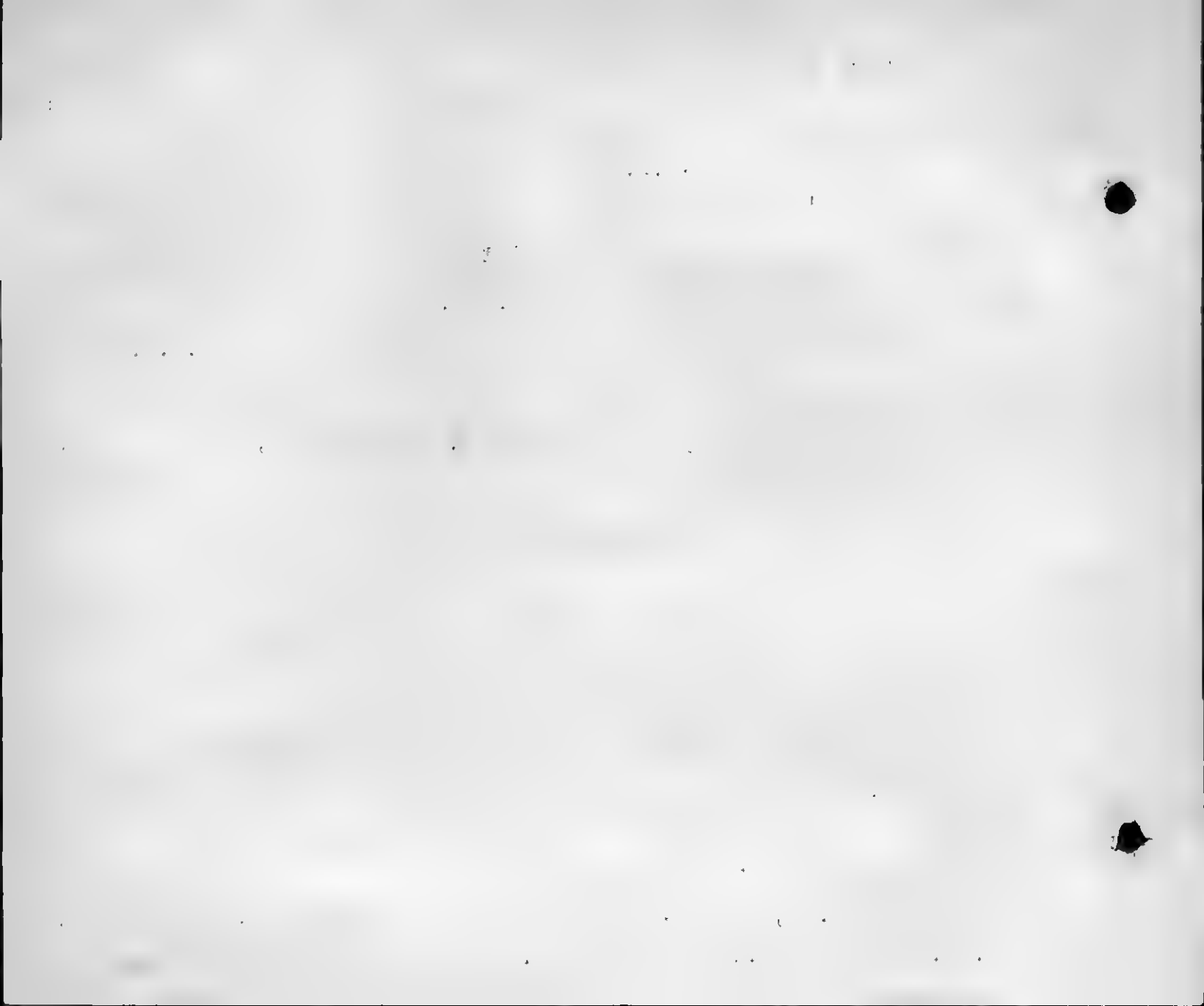
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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<div> <div>1</div> <div>01115</div> <div>011101</div> </div> <div> <div>01115</div> <div>011101</div> </div>																						
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY in 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kentland</u> d. STREET ADDRESS <u>7613 Forest Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) <u>Charles Yederlinic</u>			4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1962</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 17, 1895</u>										
9. AGE (In years last birthday) <u>66</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			11. BIRTHPLACE (State or foreign country) <u>Austria</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																				
Months	Days	Hours	Min.																			
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>108-07-4904</u>						17. INFORMANT <u>Mario A. Yederlinic</u> Address <u>434 Jan-Mar Drive, Falls Church, Va</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Rheumatic heart disease</u> (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>19</u> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)																
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																						
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>																
EXAMINER'S NAME (Type) <u>James I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>1/15/62</u>																
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>Jan. 18, 1962</u>																
22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>						22d. LOCATION (City, town, or country) (State) <u>Farmington, Long Island</u>																
23. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., Riverdale, Md.</u>						24a. REC'D BY REG. STR. <u>Arthur S. House</u>																
24b. REGISTRAR'S SIGNATURE						DATE <u>JAN 17 '62</u>																

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01116		Item 2 & Item 9 Film G305 1/17/62 iwk						01107			
1. PLACE OF DEATH a. COUNTY Prince Georges				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum (rural)				c. LENGTH OF STAY IN 1b Carroll Manor			
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum (rural) Chevy Chase			
d. STREET ADDRESS 105 Hesketh Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Alice				First Middle Last Young				4. DATE OF DEATH Month Day Year January 8 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 30, 1865		9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? Martha Jones			
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Martha Jones				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMATION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 3 weeks 26 months	
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington, D. C.		(State)	
21. I certify that (I) (this hospital) attended the deceased from 11/10/1959 to 1/8/1962 , that (I) (we) last saw the deceased alive on 1/7/1962 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Collins				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1/8/1962			
22c. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.				22d. ADDRESS 322- H. St. N.E. Washington 2, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 10, 1962				23c. NAME OF CEMETERY OR CREMATORY Wm. Olivet			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawler's Sons				ADDRESS				25a. REC'D BY REGISTRAR 1/15/62			
								25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			
								DATE JAN 15 '62			

U-113

(M)

Prince George

Charles (Knox)

Barry Henry

Alma

female white

at home

William Jones

NO

(1)

x

August 30, 1933 65

Washington, D. C.

Martha Jones

Young

January 8

35

Prince George

Marjanna

William (Knox)

La Salle Road

3 weeks

Imaginary Heart Failure

20 weeks

Accelerated Heart Failure

11/1/33 11/1/33

11/1/33

11/1/33

Thomas P. Collins, M.D. 325 - H. St. N.E. Washington, D.C.

Washington, D.C.

Jan. 10, 1933 Hst. Oliver

Burial

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01117

01108

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRMOUNT HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRMOUNT HEIGHTS</u>			
c. LENGTH OF STAY IN 1b <u>9 YRS.</u>				d. STREET ADDRESS <u>1005-57-PI.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1005-57-PI.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MYRTLE</u> <u>YOUNG</u>			4. DATE OF DEATH Month Day Year <u>Jan</u> <u>26</u> <u>1962</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>M.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 30, 1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>HARRY SHARP.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth JACKSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. INEZ PORTER, FAIRMOUNT HEIGHTS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYERTENSION</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 15, 1955</u> to <u>JAN 26, 1962</u> that (I) (we) last saw the deceased alive on <u>JAN 26, 1962</u> and that death occurred <u>4:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H.C. Beldor</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-26-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.C. BELDON.</u>				22d. ADDRESS <u>4423-HUNT-PI-ME, Wash. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1.31.62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MEM. PARK</u>		23d. LOCATION (City, town, or county) (State) <u>HIGHLAND PARK, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>WASHINGTON, D.C.</u>		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
				1820 9TH ST., N.W.			

JAN 30 '62

Arthur S. House

1111

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the purchase of land for the purpose of establishing a new settlement for the benefit of the Indians of the reservation at Fort Belknap, Montana.
I am sorry to hear that the land is not available for purchase at the present time, but I am sure that the Department will be able to find some other way of accomplishing the purpose of your letter.
Very respectfully,
J. H. ...

I am sure that the Department will be able to find some other way of accomplishing the purpose of your letter.
Very respectfully,
J. H. ...

Very respectfully,
J. H. ...